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MEDIGAP INSURANCE: COST, CONFUSION, AND CRIMINALITY

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BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

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MEDIGAP INSURANCE: COST, CONFUSION, AND CRIMINALITY

MONDAY, DECEMBER 11, 1989

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Madison, WI.

The committee met, pursuant to notice, at 10 a.m., in room 421, State Capitol Building, Madison, WI, Senator Herb Kohl, presiding.

Present: Senator Kohl and State Senator Russ Feingold.

OPENING STATEMENT OF SENATOR HERB KOHL

Senator KOHL. Ladies and gentlemen, I'd like to thank you on behalf of the U.S. Senate Special Committee on Aging for joining us today. The purpose of today's hearing is to examine the rising cost of Medigap insurance, the quality and amounts of the benefits which are being offered, and the fraudulent marketing practices by present-day agents of insurance policies at the expense of the consumers which are unnecessary and duplicative and result in untold costs, confusion, and border on criminality.

This year, approximately 22 million senior citizens will spend approximately $17 billion on Medigap insurance. Many will have one, two, three or as many as four policies at any given time. In recent years, premiums for Medicare supplemental insurance policies or Medigap policies have increased faster than the overall cost of health care, which in itself has increased twice the rate of inflation. In 1987, the House Select Committee on Aging estimated that older Americans lost about $3 billion because of fraudulent and deceptive Medigap practices alone.

The recent repeal of the Medicare catastrophic coverage care law creates an environment in which elderly citizens are even more vulnerable to price hikes, confusion, and fraudulent marketing tactics. Prior to the repeal, premium increases were expected to range from 10 upwards to 25 percent. Now that the policies are being changed to reflect the need for increased benefits, I am particularly concerned that senior citizens on fixed incomes are going to be asked to pay even higher prices for protection against illness and catastrophic health care costs.

The second question then is: What coverage are seniors getting for their money? A Federal law passed in 1980 requires that Medigap insurance companies return at least 60 percent of the premiums to the beneficiaries through benefit payments. The law was enacted with the intent of assuring, to some minimal extent, that

consumers could get a fair shake on their insurance coverage. We will look at how effective those loss-ratio requirements are.

In Wisconsin, this year's marketing of a basic Medigap policy with the option of purchasing additional benefits made it a lot easier for consumers to compare benefits, policies, and prices. And yet, I have to confess—it is mind-boggling to go through the policy comparison charts. Not only is it difficult to compare the cost of packages for a defined set of benefits, but quite frankly I'm not sure that even the most savvy of consumers can figure out exactly what some of those benefits are. Do consumers distinguish between Medigap policies and Medicare supplemental insurance policies?

And many of the plans offer a part B deductible benefit as a rider. Medicare asks beneficiaries to pay a one-time annual deductible of $75 for annual doctor bills. Despite the fact that the maximum value of that benefit is $75 per year, some Wisconsin elderly are paying $80.37 a year for it. Do I think they would pay $80.37 if they understood the most they could get for the expense is $75? Of course not. And my conclusion is that they aren't being told the value of the benefit up front.

And there are so-called phantom benefits. Benefits that are so totally dependent on a series of events: Hospitalization, Medicare payment for extended home health care, and then Medigap coverage—that you really have to ask yourself what the real value of that benefit is. But if, as an elderly person, you fear going into a nursing home and if you think that this home health benefit is going to protect you, well then why wouldn't you spend as much as $395 a year for the benefit?

Unfortunately millions of senior citizens are being snowed by some of these policies. And somehow, we have to do a better job of helping them plow their ways through these policy options.

And that comes to the third issue we will examine in today's hearing: The role of the agent in the ethical marketing of Medigap insurance and the roles of the State and Federal Governments in eliminating fraudulent insurance practices. We have had, since 1980, criminal penalties for fraudulent activities connected with the sale of Medigap policies. But are they being enforced?

We will hear from witnesses today about the victimization of American citizens. It is enough that they live in fear of catastrophic illnesses and the need for long-term care. They need not be terrorized in their own homes by unsavory agents seeking to line their own pockets with replacement commissions.

We will hear some stories from benefit specialists, who spend their days assisting Wisconsin senior citizens in sorting out unclear and noncomparable policy descriptions.

And we will hear from the insurance industry and advocates who will help the committee to formulate appropriate responses to the problems with the Medigap insurance system.

It is my hope that by the end of this morning's proceedings we will have a clearer sense of what we can do to assure Medicare recipients access to the health benefits they need, without subjecting them to exorbitant costs, confusion, and criminality.

Thank you. The Chair will now ask the first panel of witnesses to make their individual presentations. Would you please come forward?

We are fortunate to have with us today Mrs. Wilma Blum from Monticello, WI, Mr. Harold Halfin, a senior volunteer and benefit specialist from the Dunn County Office on Aging, Mr. Troy Keeling, director of the Western Wisconsin Area Agency on Aging, Eau Claire, and we are particularly pleased that Mr. Keeling is able to join us today, and, finally, we have with us State Senator Russ Feingold, a longtime spokesperson for the elderly. Russ will testify on the first panel as I understand he has some pressing business and will be required to leave us after his testimony.

Senator Feingold, would you make your presentation, please?

STATEMENT OF STATE SENATOR RUSS FEINGOLD

Senator FEINGOLD. Thank you, Senator Kohl, for holding this important hearing on Medicare supplemental insurance. We are all very pleased to have a Wisconsin Senator, and especially you, on the Senate Special Committee on Aging.

For the past 7 years I have chaired the Senate Aging Committee in Wisconsin. That position has given me an unusual opportunity to begin to understand some of the problems facing Wisconsin's older population. The problems are considerable, and as the elderly population grows, and it is our fastest growing population, those problems will intensify.

Though the social and emotional pressures are many, the economic pressures are especially serious. Contrary to a popularly held and too often repeated belief, the elderly are poorer than other adults in our country. In 1986, the median income of families with heads of household age 65 or older was less than two-thirds that of families with heads of household under 65. And for elderly not living in families, the median income was actually less than half of comparable nonelderly. For the very elderly, the disparity in income is even greater. For family heads over 85, median income is less than half of those under 65, and for elderly living alone, median income is less than 40 percent of individuals under 65 living alone.

While income for the elderly is relatively low, their living expenses are disproportionately high. Wisconsin's high property tax falls particularly hard on the elderly. In an area of special concern to our committee, long-term care costs have also gone up dramatically. The cost of a nursing home care can run higher than $30,000 per year in some homes, and averages more than $20,000. And there are long waiting lists for the Community Options Program, Wisconsin's pioneering home and community-based long-term care program. The focus of today's hearing, Medicare supplemental insurance, is yet another stress on Wisconsin's elderly, requiring attention at the Federal level. Abuses have surfaced in what was supposed to be a model of public-private partnership in providing health insurance for older Americans.

We have heard evidence of unscrupulous insurance agents selling some elderly unneeded replacement policies for supplemental insurance. With the temptingly high bounties paid by insurance companies in the first year of a new policy, some agents have been unable to resist opportunities to sell unsuspecting consumers supplemental policies they probably don't need.

The problem is compounded by the inability of a policyholder to cancel a supplemental policy in mid-term, or to receive a refund for the unused policy. This means that older consumers may be saddled with several policies at one time, having to pay for all of them, but receiving no additional coverage.

I assume most insurance agents act ethically in providing the elderly with supplemental policies. In fact the problem of multiple replacement policies caused by high first year commissions was brought to my attention by an insurance agent who is a constituent of mine from a rural area. He proposes that we prohibit those high first year commissions and instead allow only the lower replacement commission, thus eliminating an incentive to push more and more policies on an unsuspecting consumer.

We should also do a better job of educating agents on Medicare supplemental insurance, though, as they may often be as confused about changing Medicare coverage as are consumers. This is even more likely now, with the controversy over the Catastrophic Health Act.

Beyond the problem of face-to-face sales tactics of some insurance agents, consumers are too often duped into buying unneeded policies by the slick television advertising that features popular, and trustworthy celebrities promoting supplemental policies. By merely calling a toll-free number, older consumers can buy the same policy their favorite TV star claims to have. Those ads can be extremely persuasive, and as a result, some elderly end up with a dozen or more Medicare supplement policies. These telemarketing firms are beyond the reach of our State regulators, making it nearly impossible for Wisconsin's government to protect its consumers in this area.

Another concern is the wide range of prices currently charged by different insurance companies for essentially the same policy. In one example, the rate for one policy described in the "Individual Medicare Supplement Insurance Policies" packet published by the Office of the Commissioner of Insurance [OCI], one insurance company charges over 60 percent more than another company for a Medicare supplemental insurance policy with identical benefits—a difference of nearly $300. Adding to the rate disparity problem are the policy riders that, in some instances, cost more than the benefit they cover. The OCI packet noted earlier lists one insurance company that offers a rider to cover the $75 part B deductible. That rider cost $99 to purchase!

Let me say, however, that Wisconsinites are fortunate in a couple of respects. First, we have the Medigap Hotline, administered by the Board on Aging and Long-Term Care. They do an excellent job of providing older consumers with help and information about Medicare supplemental insurance policies, as well as other issues. And they are an excellent source of information for the legislature both in directly helping our constituents and as we develop policy on aging issues.

Second, we have several effective consumer advocacy groups, and I would especially bring to your attention the Coalition of Wisconsin Aging Groups and the Center for Public Representation. Both the coalition and the center have representatives here today, and I

know their suggestions and recommendations carry weight with this committee.

Finally, Senator Kohl, as you seek solutions to the problems of Medicare supplemental insurance, I urge you to apply the lessons we are learning from this public health care insurance system to the area of long-term care. Reforming Federal long-term care policies and programs is the greatest need of older Americans and should be the highest priority of Congress and the Senate. Your hearing here today is a clear sign to the people of Wisconsin that the concerns of older people in this State are at the top of your legislative agenda.

Thank you.

Senator KOHL. Thank you, Senator Feingold.

Mrs. Blum.

STATEMENT OF WILMA BLUM, MONTICELLO, WI

Mrs. BLUM. Good morning, Senator Kohl. My name is Mrs. Wilma Blum. I am 77 years old and my husband is 82 years old. We have been residents of Monticello, WI, for over 50 years. I appreciate the opportunity of sharing my experiences with the Senate Special Committee on Aging, and I hope the testimony I'll give today will help other senior citizens avoid the experiences that I and my husband have had.

My husband and I had separate supplementary policies with the same insurance company—Guaranteed Trust. His initial premium was approximately $300 and it went up by $100 in each of 4 years. The benefits did not increase in relation to the rate increases. My policy, with the same company, cost me $197.87 per year.

In 1985 an insurance agent came to our home uninvited. My husband and I told her that we were unhappy about our Medicare supplemental policies. The costs kept going up and we didn't think the benefits were very good. She sold us new policies with United American at a cost of $789 per year for the two of us.

We kept United American for almost 2 years. In 1986 we were paying over $1,200 for our two policies. The agent gave us the impression that the Central States policy would pay 100 percent of whatever outstanding medical bills we might have. Both my husband and I had surgery and we found that the 100 percent coverage was not there.

Then in 1987 we bought a National States policy for my husband—$857 per year. My husband got ill, and National States gave poor service in paying. We still had the United American policy, and the premiums had reached $1,051 per year. Sometime in 1987 the agent came back and said she had a better supplemental policy that involved less paperwork. She sold us a policy with Central States Insurance, with a yearly premium of $930.18 for myself and $1,127.36 for my husband. We have had Central States for nearly 2 years. We were told that Central States would pay 100 percent of medical bills after Medicare but it has not.

We now must make a decision to purchase another policy or to continue with Central States. I realize that these numbers may be confusing. They certainly have been to us. But we cannot be without supplementary insurance at our age. It was only when the

Green County Benefit Specialist, Ruth Flannery came to see us that we were given any helpful information about the kind of health insurance choices we are trying to make.

I hope what has happened to us can be prevented from happening to other senior citizens. We get so little information and often the insurance agents promise to explain these policies to us but never do. Thank you again for holding these hearings. I will do my best to answer any questions you might have.

Senator KOHL. Thank you for a fine statement, Mrs. Blum.

Mr. Halfin.

STATEMENT OF HAROLD HALFIN, VOLUNTEER, DUNN COUNTY OFFICE ON AGING

Mr. HALFIN. I'm Harold Halfin from the Dunn County Office on Aging. I'm a volunteer and I work for a number of people as a Medicare helper and, in addition, I have had training from the Office of the Commission of Insurance regarding Medigap policies. I also enroll people, who qualify, for the Partner Care Program.

I serve in the northern part of Dunn County as a volunteer, and I would like to speak this morning from the point of view of consumer protection for the elderly.

I would like to speak from the point of view of consumer protection for, in the majority of cases, the female elderly. This is not to say that the male elderly does not have a problem. In rural west central Wisconsin the majority of people calling for help are the vulnerable female elderly whose husband in many cases took care of the books and paid the bills and when he died she did not have any inkling of what to do or how to do it. These female elderly may or may not be low-income elderly. Some are just above medical assistance income while some have sufficient funds. Some are on PartnerCare. Some have a visual problem while some have difficulty reading and understanding the written word. Some are very lonely and some have no family in the immediate area.

With the above background I would like to discuss three different cases where the elderly have been subjected to unethical insurance agents. These agents are determined to sell their policies even though the additional policy or a policy change is not necessary. They—the agents—butter up these female elderly and they—the elderly—buy another policy or a replacement policy. Sometimes, in taking the application the agent fills out the application not listing the preexisting conditions and when it is time to collect the insurance company will not pay because they say it is a fraudulent application.

Case No. 1: A widow, 92 years old, whose income is just above the medical assistance level but eligible for PartnerCare thought she was buying insurance coverage for a nursing home. She currently has a comprehensive Medigap policy with an HMO. An insurance agent called on her and found she was concerned about nursing home coverage and proceeded to tell her he had the policy she needed. She paid him $861 for another policy which was nothing more than a Medigap policy with coverage considerably less then her HMO. The agent would have collected 60 percent or $516.60 for this day's work.

Here is a case where the agent was so nice and told the lady that she needed help and he was there to help her using what I call the nice guy syndrome and instilling fear in her about the need for nursing home coverage. After 3 weeks she wondered if she had done the right thing and called the Office on Aging. We wrote the company about the policy; we also wrote the complaint department of the Commissioner of Insurance about this unethical practice. This agent did not follow correct procedure because all agents are to provide an OCI brochure on Medigap policies prior to any sale. This he did after the sale. Also the signature of the agent was illegible and no address was given. As yet she does not have her money back.

Case No. 2: A 76-year-old widow who shows serious signs of dementia has no family support and loves to have visitors. She also is unable to say no to insurance agents. Her banker asked the county benefit specialist to investigate when this woman was overdrawing her accounts due to a number of large checks written to insurance companies. During a 2-year period this woman had bought 15 different insurance policies. Two other additional Medicare supplements had recently lapsed. The policies included seven Medicare supplements, one daily indemnity, five life insurance, and two cancer policies.

Upon investigating it was obvious that this woman had no understanding of insurance. She didn't even know the difference between life insurance and a Medicare supplement.

Several agents switched her regularly every year to either a new company or a new policy for her Medicare supplement. Other agents sold her one of each kind of policy.

With the assistance of the benefit specialist and the Office of the Insurance Commissioner some money was recovered, however, most of the policies lapsed or were canceled.

Three years later this vulnerable woman still has little protection from unethical agents. Her banker, neighbors, and social worker try to check on her regularly. However she is unwilling to ask for help, has no family, and the court system is unwilling to intervene saying she is still competent to make her own decision.

Case No. 3: This involves a couple who purchased a supplemental policy and the insurance agent completed the application incorrectly on preexisting conditions. There are questions on the application that ask about the possibility of preexisting conditions. These questions were, according to the couple, answered honestly detailing the preexisting conditions of the wife. The agent answered "yes" to the question whether she had been advised by a physician * * *, and the agent proceeded to check "no" on medical history of the wife even though she told the agent of her medical history. The wife became ill and later filed a claim which was refused on the basis of a preexisting condition not shown on the application. This couple had to pay or is paying out of their pockets for this tragic mistake which should not have happened.

What is needed is a rule or legislation that requires agents to be more responsible for their actions. Possibly a form requiring the agent to indicate whether the policy he/she is trying to sell is a new policy, an additional policy, or a replacement policy. The agent should indicate why the different policy is better and detail exactly

what is covered on a separate sheet of paper. The agent should sign the form and come back at a later time to get the person's signature and payment. This form would become part of the policy and it would also be sent to the Office of the Commissioner of Insurance. Such a rule has been proposed by the Commissioner of Insurance.

One last note, the people I contact are only a small portion of those needing assistance with Medigap insurance issues.

Thank you, Senator, for the opportunity for being here today.

Senator KOHL. Thank you, Mr. Halfin. That's a fine statement.

Mr. Keeling, thank you for being here today.

STATEMENT OF TROY A. KEELING, EXECUTIVE DIRECTOR, WESTERN WISCONSIN AREA AGENCY ON AGING, EAU CLAIRE, WI

Mr. KEELING. Thank you, sir, Senator Kohl. I was pleased when I learned you were going to be on this committee. When you first went into the Senate we thought maybe it would have been better for you if you had gone into banking, but my agency has enjoyed working with you and with your field staff here in Wisconsin.

For the record, my name is Troy Keeling. I am director of the Western Wisconsin Area Agency on Aging. This agency serves 19 counties and 2 tribes in rural Wisconsin. Thank you for this invitation to speak to the concerns of this region's elderly population. Medicap supplemental insurance is problematic for aging persons here, as well as for those throughout this Nation. I will speak directly to, and from, the consumer-beneficiary perspective.

The term "Medigap" identifies the real problem. The need for gap filling insurance creates and nourishes an entire family of anxieties for older people. The supplemental insurance policies, their benefits or lack of benefits, fright-filled multipurchasing, along with other complex concerns, represent confusion and doubt in all elements of the supplemental insurance constellation. The elderly are confused over, and by, the complexity of Medicare, confused by the quasi-governmental sounding language of private Medigap supplemental insurance policies, confused by the bewildering plethora of advertised promises of insured salvation and confused by government and private insurance company exercises in frail attempts at clearing up the confusion. Administrators and providers of medical services are entrapped in red tape confusion in attempts to decode for the elderly the complicated payment system. Even the advocates for the elderly and aging programs are confused by the unclear messages sent out by the Federal Government even as it attempts to wander through a self-created maze of the complicated solutions.

The elderly, after 24 years of Medicare, don't understand why the government, along with private insurance, can't or won't provide comprehensive, all-inclusive health insurance. They wonder at the very idea of a gap between Medicare, for which they pay an ever-increasing price, and the actual cost of their medical care. Older persons hear of other nations close by and far away providing either national health insurance or national universal health care and continue their wondering. A gap between their health care needs and the Nation's inability to provide health care with-

out their being reduced to penury doesn't square with the image they have carried from the cradle of a beneficient democratic Nation.

The rising cost of Medicare supplemental insurance is, of course, directly related to the ever-higher cost of medical services and the reforms in Medicare throughout the present decade which reduced paid-for services while continuing obtuse policy language, further confusing the consumer. The growing sense of a lack of security and the need to feel secure at least in being prepared for future health needs, has caused older people to neglect the most basic of their needs in order to not go the dreaded welfare route. The public mind, which now leans more to a "greedy geezer" portrait of the elderly, doesn't focus well on improved benefits through Medicare. The growing sense of insecurity gains credence by the growth of the elderly's increase in daily living expenses and growing debt in many elderly families.

The growing insecurity caused by a widened gap in cost and coverage has made the elderly prey to insurance activities and their own imprudence caused by fear. The very ethics older people have been raised by breaks down with increased fear of not being able to take care of their own needs. For various reasons, some frail elderly find that the way out of their dilemma is to break the hard gained nest egg and stock up on insurance coverage.

In the 1980's, the State of Wisconsin's Aging Network has found a partial solution to eliminating the confusion, fear, and insecurity caused by the complexities of paying for health care. Supported by the Coalition of Wisconsin Aging Groups and other advocacy groups, the Bureau on Aging, of the State Department of Health and Social Services, created a benefit counseling service. At first funded only with Title III–B funds under the Federal Older Americans Act, the State's area agencies used their funds to give legal back-up to a county service to older persons. Over the past years, since 1983, the State legislature and administration has added significant funds to the program, allowing for a benefit specialist in all 72 counties, at least on a part-time basis.

The well-trained corps of benefit specialists, known as tape cutters, work in the counties through the county aging units. Older consumers are guided through the maze of paperwork assisted by one-on-one contact and through group training in understanding the complexities of the Medicare system. One of the most important services offered by this well-run, if underfunded program, is in the area of medigap supplemental insurance. Senator Kohl, it would be hard to imagine the State of Wisconsin going back to a haphazard system of information provision now that the elderly are provided with a service which helps explain a system and at the same time assists the consumer through their insurance problem. The benefit specialist is kept informed of changes in the State insurance laws and in Federal Medicare. This important service is given legal and benefit counseling back-up by the State's area agencies on aging.

I would suggest that the State of Wisconsin's model for offering benefit counseling could be built into the Medicare system. As the Federal laws change and grow even more difficult to track and understand, one serious problem grows for the elderly. That is having

the ability to know and understand what is available in insurance and service. Not knowing causes a vulnerable portion of our society to live lives in fear and anxiety. The Social Security Administration now does its main business with an aging population by telephone. The Veterans' Administration is reducing counseling services while eliminating their transportation resources at a time when the number of aging veterans increases. A better informed consumer will eventually decrease the communication problems for the Medicare system. If the Federal Medicare system doesn't care about the fear and insecurity caused by a complex program, then Congress has a very clear mandate for real reform.

Speaking on the floor of the Senate on November 21, 1989, during the debate on the Medicare Catastrophic Act of 1989, Senator Weiss, speaking of the recent estimates which indicate that there are over 37 million people with no health care insurance coverage in the United States, made the following statement:

> The United States is the only major industrialized nation, with the exception of South Africa, that doesn't have a national health plan for its citizens. Although establishing a national health plan is not the issue at hand today, I would like to reaffirm my strong support for such a plan. I believe that all Americans—young and old—are entitled to quality medical care.

This advocate for the elderly maintains that given the fact that the State and Federal Government is apparently not yet ready to provide for a national health service, now is the time to advance the cause of a national universal health insurance program. At the very least, Congress could assist State government with the institution of Medicare certification for basic coverage policy on the order of QMB. Private insurance then would offer coverage as if under a national seal of approval. The conditions which caused the problem for the consumer of Medigap insurance are the complicated language in policies, the complicated coverage items and the seriously complicated consumer evaluations. These conditions breed aggressive agents who are tempted to mislead, oversell, and misrepresent.

Again, Senator Kohl, I thank you for the opportunity to appear here today to continue with you the effort to take some of the confusion and insecurity out of the Medigap insurance picture. A secure feeling of having adequate insurance will go a long way in enhancing the lives of older people.

Senator KOHL. Thank you, Mr. Keeling, for a very fine statement.

Mrs. Blum, I'd like to ask you just a few questions. Mrs. Blum, how did you find out about the county's services and while you were struggling with these various policies did you ever try to get outside help?

Mrs. BLUM. No, we did not. This lady who was selling us insurance acted like she was doing us a good deed, but she was not because every time the policy was changed we'd have to have a new policy; we'd have to have a 90-day waiting period. So, that was hard.

We had to pay the extra 3 months there. And then, each time the policy went higher so she was making pretty good money, I think.

Senator KOHL. So you weren't in a position to deal with outside help; you were dealing with the insurance agents and you thought they were providing you with all the information you needed?

Mrs. BLUM. I thought she was doing us a good job. I had talked to a social service lady one other time.

This one time when my husband went to National State's policy the insurance agent came there when I was not there and he talked to my husband and he tried to tell him how good the policy that he was selling was going to be for a nursing home. Of course, that kind of sold my husband.

And then, of course, we had the other policy in force and we thought we'd better keep it and, here, before the 90 days were up he got sick and had to go to the hospital. So, we didn't get—they didn't want to pay much for the claim.

Well, I can see where they didn't, but finally—they kept on sending bills back and forth to our doctor. and finally I went there one day and I said, "What is wrong here?" An office girl said, "We have had so many papers that they sent us to fill out," and she says, "We have done the same thing many times and we don't know what to answer them anymore."

So, the insurance man called up my husband and he says, "What's wrong?" And he says, "I'll tell you what's wrong. Our doctor here is having a fit because we have sent these bills in time and time again and answered your questions but we have to answer the same thing every time."

So, then we did get a lump-sum settlement but we did keep the other insurance in force because we knew we weren't satisfied with National States.

Senator KOHL. And you paid the huge premiums to four different companies?

Mrs. BLUM. Two different companies.

Senator KOHL. Were you aware of the fact when you wrote these policies with them that 60 percent of the first year's premium went to commission for them? Did they make you aware of that?

Mrs. BLUM. No.

Senator KOHL. You were not aware of that?

Mrs. BLUM. No, but we started to get wise to it.

Senator KOHL. Do you believe today that in your case that this particular agent was probably switching your policies in order to make money for herself?

Mrs. BLUM. I thought she was. She called me the other day and I was very short with her. And I said—we've got two things; I've got another thing with her. And it's with my life insurance policy, and she has done a very nasty trick with me, but I can't present that today.

Senator KOHL. Do you feel, Mrs. Blum, that you and everybody else has a right to be protected against insurance representatives like this one?

Mrs. BLUM. Yes, we do. We trusted her, but I don't anymore.

Senator KOHL. So, the relationship between yourself and many, many other people who seek to purchase the right policies and the insurance agent, while oftentimes depicted as a friendly, trusting, cooperative relationship, really isn't that kind of a relationship. Is that an accurate statement?

Mrs. BLUM. That's right.

Senator KOHL. And there's nobody between you and them to inform you and protect you?

Mrs. BLUM. Well, there probably would have been, but I guess——

Senator KOHL. No, that you knew of?

Mrs. BLUM. That's right. You know, social services has been in our town for a long time and I talk to her occasionally but, I don't know, I just didn't realize how far you could go with it.

And when your policy comes due you're naturally not going to let anything lapse. We wanted to get it straightened out.

Senator KOHL. Absolutely, that's very good.

Mrs. BLUM. That's what our problem was. That's why we stuck with her.

Senator KOHL. Mr. Halfin, do you regard Mrs. Blum's situation as typical?

Mr. HALFIN. Typical.

Senator KOHL. Typical?

Mr. HALFIN. That's right, in rural Wisconsin.

Senator KOHL. In rural areas?

Mr. HALFIN. Um-hum.

Senator KOHL. Are you saying to us today that you, as an experienced person who understands this field and understands what Mrs. Blum has just said and has had many years of involvement with regard to her situation, at least in terms of rural areas, it's not atypical at all?

Mr. HALFIN. I can give you numerous cases where people who are elderly—female and in some cases husband and wife—do have two policies but only need one plus a cancer policy.

Mrs. BLUM. We had that too.

Senator KOHL. You had that, too?

Mrs. BLUM. We had a cancer policy; but not from her.

Senator KOHL. OK. Mr. Halfin, in the case of that 92-year-old woman you talked about, could you tell us the name of the insurance company involved?

Mr. HALFIN. Guaranteed Life and Trust of Glenview, IL.

Senator KOHL. Guaranteed Life and Trust, OK. I'd like to know that if the woman is willing to share information with you or me and my staff. Perhaps we can be of some assistance. I would like to pursue that with your permission and your help.

Mr. HALFIN. Yes, I'd appreciate that.

Senator KOHL. Mr. Halfin, do you think more of the responsibilities should be placed on the seller to avoid selling duplicative policies and replacement policies. Or, if the agents didn't have such strong incentives to sell replacement policies and duplicative policies, do you think that would help?

Mr. HALFIN. Yes, definitely.

Senator KOHL. Do you regard that as one of the worst abuses to the system?

Mr. HALFIN. Yes, during the first year. In other words, first they make the sale and then they come back a year later and tell them, "I have a better policy now. I think you should buy this." And they sell again, sell again, sell again, and sell again.

Senator KOHL. Well, how can we see that this pattern is not repeated in the future? I'm assuming that for most older Americans, as well as most citizens trying to understand these policies, it is really very difficult, if not impossible, and most of us need help.

Mr. HALFIN. Yes.

Senator KOHL. I would say that about myself if I were buying one of these policies. How do you suggest that we do something that will eliminate this problem? What would you suggest?

Mr. HALFIN. I would have a separate sheet detailing exactly what is in the policy if it's a new policy—1, 2, 3, 4, 5, 6, 7, 8—or if a replacement policy it must be compared with the policy it is to replace. The agent must sign it; also, a friend must sign it, and then, the person buying the policy would sign it.

And if, in some cases the person doesn't have a friend to sign the agent signs that he/she is responsible for duplication, and errors of omission. We need to have those agents pay for some of the mistakes they're making for these people.

Senator KOHL. Are we pursuing these agents that are making these mistakes? Is there any real pursuit at any place in our State that——

Mr. HALFIN. Let me say that at least by writing the Commissioner of Insurance we do get a response. I think we have a very good advocate in the Commissioner of Insurance Office—I'll name her—Donna Bryant—and she does help a great deal.

Senator KOHL. After the fact?

Mr. HALFIN. Yes.

Senator KOHL. Would it be helpful if every senior citizen were required to get the help of a professional?

Mr. HALFIN. That would be very good, yes. It would be helpful also to wait for a week or a lapse of time, before payment is made so that the person has the opportunity to get help if necessary.

Senator KOHL. No signing on the spot?

Mr. HALFIN. No signing on the spot or making any payment on the spot.

Senator KOHL. Do you think that's a good suggestion, Mrs. Blum?

Mrs. BLUM. Yes, it is.

Senator KOHL. Is there a big push when you're sitting with the insurance agent to get it signed?

Mrs. BLUM. Yes, and if you don't they don't leave you alone; they call you back and get you really confused.

Senator KOHL. Let me ask this question. What would be wrong with a system whereby when you have an insurance policy you want to sign in 7 days you send it to a place of government professionals that have a chance to look it over and send it back or call you, or whatever else, so that, when you sign it you'll know that somebody who is very competent has looked it over first and told you it's a service to buy. Would that be helpful?

Mrs. BLUM. Yes.

Senator KOHL. Mr. Halfin.

Mr. HALFIN. Yes. However, if it's a replacement policy how much better is it than the replaced policy has to be detailed also.

I had a lady tell me recently that she had an agent in her house for 6 hours determined to sell her a policy.

Mrs. BLUM. Mine was there for 2 hours.

Senator KOHL. Mr. Keeling, how do seniors needing your services find out about them and how many people do you serve in your area? How many resources do you have to do outreach?

Mr. KEELING. We're fortunate to have fairly good resources to do outreach in this State. Agent services are done through what we call county-based planning where 72 counties have units and the Bureau on Aging serves these 72 counties.

So, we do have professionals in all of the counties. They are, of course, generally overworked and understaffed but every one of those counties attempts to get out newsletters through the senior center and through the meal sites and various outreach programs. They attempt to get into the homes with the message of how to buy insurance, how to have access to good information.

The problem I think that I sense is that we tend to always start with the little people in the United States, and the little people sometimes are the victims of a bigger system.

And I think that one of the things that we've discovered in our area is to try to get the big people and the big people are the insurance companies, themselves.

Also, it's people in government who are not being clear, not passing the right kind of laws, not taking the right kind of surveillance, and I think it's also our own agencies.

I envision this happening. A young person out of work finds a job, takes a job as an insurance agent or someone fresh out of college, someone who has a master's degree, someone who has long years and skill at the lathe or something. It's usually somebody who has an unfortunate circumstance.

And I envision this kind of person going out there in their one suit and one tie attached, and everything, wanting to bring home money to the family. They're probably in debt, probably mortgaged the car, and they have incentives to find themselves in a position to do unethical things.

But it seems to me that if the insurance industry were regulated in such a sense they would be able to create a system that would not tend to prey but would tend to be very helpful.

I, for one, am a little discouraged with the primary insurance industry. I have not seen an awful lot of stomach or heart on the part of insurance companies, Senator, to do much other than to try to sell insurance for a profit motive.

So, I've seen very little imagination between government and private insurance in trying to assist these people and trying to get the little people, trying to get the information out to the little people and do a pretty good job of it.

I am pleased with all of the persons who are here with us and all of the staffs and all of the aging units in our counties. They do yeoman's work. They are working in the areas and they're working with the victims. Most of them are victims themselves because the system doesn't back them up, doesn't give them muscle, and doesn't look to what the real problems are.

You and I both know that the real problem is limited care long-term support itself. So, Mrs. Blum and her husband have worked hard for their nest egg; they don't want to cause you or me or anybody else a problem, and they find themselves in the very pursuit

of that care, falling into traps that hurt them and make their life almost unbearable.

Senator KOHL. Well, this has been remarkable and I want to thank you all for making the effort to come here today, and I want you to know that what you've said is going to cause some action to be taken. Thank you very much.

Mr. KEELING. Thank you very much. It was nice to be here.

Senator KOHL. I'd like to call our second panel at this time. We have with us David Becker of the Arneson/Becker Insurance Agency in Mount Horeb; Geralyn Hawkins, the benefits hotline specialist for the Wisconsin Board of Aging; Robert Haase, Wisconsin State Commissioner of Insurance; and Tim Cullen, Vice-President of Blue Cross and Blue Shield Insurance Co.

And it's good to have you all with us this morning, folks.

Tim, would you like to start off?

STATEMENT OF TIMOTHY F. CULLEN, VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN

Mr. CULLEN. I certainly would, Senator.

I appreciated hearing Senator Feingold's comments this morning. I had the privilege of helping establish the first Senate Committee on Aging as I was the first Chairman of that Committee. I also had the privilege as Senate Majority Leader to appoint Senator Feingold to succeed me. He's done an outstanding job in that capacity.

Thank you for the opportunity for Blue Cross and Blue Shield to participate in this hearing. We believe that government monitoring and government regulation of Medigap policies is not only appropriate but badly needed today. To get right to the issue, I would like to focus first on the Medigap insurance sales arena following the repeal of catastrophic coverage under Medicare.

How does repeal impact on private insurance sales activities toward senior citizens? The act of repeal becomes a sales tool. Agents can tell seniors that "now more than ever" you need a policy to fill the gaps in Medicare.

What actions can government take to protect consumers? Number one, more rigorous enforcement of the existing laws. Current law requires loss ratios of 60 percent on individual policies and 75 percent in group policies. Loss ratio is a term stated in the negative. Consumers benefit from higher loss ratios. The higher the loss ratio, the higher the percent of the premium dollar that is paid out in claims and the lower the percent of the premium dollar that is kept by the insurance company. A higher loss ratio generally means a better value to consumers.

The attached list shows the loss ratio of companies selling individual Medigap policies in Wisconsin in 1988. As you can see, 14 of the top 20 sellers had loss ratios below the required 60 percent. Although the numbers are complex, let me put this issue into dollars. A large majority of the business on this list is, in fact, Medicare supplement business. If regulation and enforcement were toughened to bring the average up to 60 percent minimum, elderly consumers would save more than $10 million per year.

The second thing the Government can do is more rigorously prevent agent abuse. I call your attention to an incident in Fond du

Lac of an agent representing himself as a Blue Cross and Blue Shield agent to gain access to a senior citizen in order to talk her into switching her coverage to a company that pays higher first-year commissions. The company the agent was encouraging her to switch to had a 54 percent loss ratio in 1988, and much higher first-year commissions than Blue Cross and Blue Shield.

Blue Cross and Blue Shield pays low commissions on Medigap policies—a flat $36 per year—much less than 10 percent—so that agents licensed with several companies can see a financial incentive to switch peoples' coverage to companies that pay higher commissions.

The Government could raise the required loss ratios. This not only gives the policyholder more of their premium dollar in benefits, but it also restricts the insurance company's ability to pay high commissions, which only encourages the possibility of agent abuse.

How can rate increases on Medigap policies be controlled? Given the deregulated health care field in Wisconsin, the best single tool is probably putting more managed care provisions into Medicare itself. Currently Medicare only has managed care on the hospital side. Managed care on Medicare will lead to more managed care on Medigap policies.

Senior citizens would probably be better served by having Medigap policies marketed through reputable senior citizen organizations, such as the Coalition of Wisconsin Aging Groups.

I look forward to your questions and comments. Thank you.

OTHER INDIVIDUAL ACCIDENT & HEALTH

RANK	INSURER	% OF MARKET	PREMIUMS WRITTEN	LOSS RATIO
1	BLUE CROSS & BLUE SHIELD UNITED OF WI	12.2	$ 43,317,887	66
2	WISCONSIN PHYSICIANS SERVICE INS CORP	8.8	31,358,157	71
3	BANKERS LIFE & CASUALTY CO	6.0	21,522,267	55
4	AMERICAN FAMILY MUTUAL INS CO	5.7	20,309,163	57
5	PHYSICIANS MUTUAL INS CO	5.2	18,424,097	65
6	TIME INSURANCE CO	4.6	16,452,209	43
7	AMERICAN FAMILY LIFE ASSUR CO OF COLUMBUS	4.6	16,450,947	51
8	COMBINED INSURANCE CO OF AMERICA	4.2	15,168,145	39
9	MUTUAL OF OMAHA INS CO	3.8	13,430,595	59
10	UNITED AMERICAN INS CO	3.4	12,018,028	54
11	STATE FARM MUTUAL AUTOMOBILE INS CO	3.1	11,019,536	71
12	MIDAMERICA MUTUAL LIFE INS CO	2.2	7,828,529	72
13	AID ASSOCIATION FOR LUTHERANS	2.1	7,591,375	62
14	NORTHWESTERN MUTUAL LIFE INS CO, THE	2.0	7,343,491	47
15	CONTINENTAL CASUALTY CO	1.6	5,875,314	42
16	CENTRAL STATES HEALTH & LIFE CO OF OMAHA	1.5	5,313,354	39
17	GOLDEN RULE INS CO	1.4	5,203,794	46
18	DELTA DENTAL PLAN OF WI INC	1.4	5,162,895	90
19	PIONEER LIFE INS CO OF ILLINOIS	1.3	4,895,455	10
20	PENNSYLVANIA LIFE INS CO	1.1	4,130,309	49
TOTALS FOR	20 RANKED INSURERS	77.15	$ 272,915,558	59
TOTALS FOR	352 INSURERS WRITING THIS LINE	100.00	$ 353,744,235	57

SOURCE: Wisconsin Insurance Report, Robert D. Haase, Comissioner of Insurance, Business of 1988, p. 118.

Senator KOHL. Thank you, Tim.
Mr. Haase.

STATEMENT OF ROBERT D. HAASE, WISCONSIN STATE COMMISSIONER OF INSURANCE

Mr. HAASE. Senator Kohl, I think probably you could read my speech. I'd rather talk about some of the things that have been coming up this morning, and then, if you have any questions I'll be glad to answer them.

Quite a lot has occurred in the last 2 years in the area of Medicare supplement insurance. I've just come back from the National Association of Insurance Commissioners meeting, and while we were waiting to find out whether or not President Bush is going to sign or veto this bill we adopted some rules which do some of the following things.

One of the things that came up this morning is this problem of switching, churning, or twisting. What we adopted was a premium level approach, which will become the law in the State of Wisconsin. Under the rule the first year commissions could never be greater than 200 percent of the renewal commissions; commissions provided in subsequent years must be equal to the commissions provided in the second year and for a number of years; and on replacement policy sales the commission can be no greater than the replaced insurer's renewal commission unless the benefits are substantially greater than the benefits under the replacement policy. The only commission you can receive is what the renewal commission would have been on the policy you are switching.

This will be the law all over the country shortly because, as you, I'm sure, are aware, under the Medicare bill when the National Association of Insurance Commissioners adopts rules, they become the law as soon as the States adopt them. If the States don't adopt them they become law anyway. So, that is one of the things that will be done to help solve this problem.

Second, there are a number of other things that have been done. There is a 30-day look-see regulation that the person is guaranteed after they buy the policy. They have 30 days in which they can say they want to cancel it.

In addition to that, it's always been against the law to make any misleading or false statements or to use high pressure tactics.

So, as soon as the bill is signed into law they will be unable to use cold-lead advertising, which is where an agent simply tells a prospect that you are coming to see them. The agent must disclose in a conspicuous manner the purpose of the meeting and who they are representing.

Whenever an agent goes to sell a prospect a policy they have to give them one of our booklets from the Department before they can make the sale. Of course, the person is not going to have much of a chance to read it, I suppose, but that's the best we can do with it.

It does explain a lot of the problems that exist and, also, tells you how to contact our Office if you're having problems with what's going on.

A sale which would provide an individual with more than one Medicare supplement policy is prohibited unless the two policies together would cover only 100 percent of a person's needs.

Also, from now on every insurance company will be required to report to the Insurance Commissioner's office on an annual basis any policy holders who have more than one Medicare supplemental insurance policy in force with that company.

It has been possible up to now to replace one policy with another and then start another 6-month waiting period, or whatever it has been. Now that will not be possible. If you're going to replace a policy with a policy if they've already got their 6 months in you have to accept it as is.

So, I think these things will to a large extent from the legal end of it, at least, discourage agents from twisting and churning and selling more policies than are necessary.

As far as the rate regulation is concerned the law in Wisconsin is that you have to have at least a 60-percent loss ratio, as Tim pointed out, for individual policies, and a 75-percent loss ratio for group policies. The average in Wisconsin last year for the full State for the year 1988 was 67-percent which means that they were above the 60-percent loss ratio.

And maybe that isn't high enough. I'm not here to say whether it is or isn't. That's something for someone to decide. But we have had that and it has kept rates down in Wisconsin. Not every State has done it this way.

As a matter of fact, the assumption is that the rate increase in Wisconsin next year will be about 11 percent, whereas, in many of the States it's going to be well over 100 percent.

And so, while I'm not bragging about it, I'm just simply pointing out some of the facts.

Also all the new Medicare supplement policies will have to include the rates they will be charging. We will have to have a filing to include the impact of the repeal of the Medicare Catastrophic Act.

And if it was stated in 1988 that they were reducing their premiums because something was worth 10 percent and now they want to increase their rates in 1989 because that is gone we're not going to let them say, "Now it's going to be 20 percent." If they want to increase it they will have to use the same figures that they used in the past.

We try to monitor these things as much as possible. Obviously, there is a problem with education, and we have Donna Bryant and others in our department who meet regularly with the county benefits specialist who was talking to you this morning, holding training seminars all over the State of Wisconsin on a regular basis.

They'll be going out again now with the new changes to bring them up to date as to what is in the bill, what is in the law, what kinds of things are problems, and so forth. And we'll be doing that again because it has changed. We also have a Medigap hotline number that they can call free if they have any questions.

But I do think it is possible to get a better educational method for the information to the older people. That would be probably as great a benefit as any because in all forms of insurance none of us do enough shopping around; none of us really understands, includ-

ing myself, what's in the policy we're buying and we should. We take somebody's word for it—the guy or gal, we play golf or bridge with.

And if there's a way to educate people as to what is there, what is better, that they should contact the professionals who are in the counties or call our office with any of these questions, we should find that.

So, with that let me close and let me thank you for inviting me. I'll be glad to answer any questions.

Senator KOHL. Thank you. Commissioner.

Mr. Becker.

STATEMENT OF DAVID L. BECKER, ARNESON/BECKER INSURANCE AGENCY, MOUNT HOREB, WI

Mr. BECKER. First of all, I appreciate the opportunity to be here.

I'm a marketer of insurance. I have chosen this profession for the last 21 years, and I have found myself exposed to the use and abuse of marketing practices in the Medicare supplement area.

My purpose today is to discuss the marketing practices of Medicare supplement policies by the independent agent. I will describe an abuse of the delivery system and present a possible solution to the problem.

Independent agents have an opportunity to gain a great deal financially at the expense of both the public and the companies they represent. They can secure contracts which pay as much as 75 percent of the first year premium as their commission. Renewal commissions range from 5 to 12 percent.

I will describe a scenario today using an annual premium of $1,200 per year, first year commission of 60 percent, and renewal commission of 10 percent.

The events I will describe are presently a daily occurence in Wisconsin.

The agent makes a call on a prospect and writes a Medicare supplement policy. He collects $1,200, and keeps 60 percent, or $720 of the premium as his commission. Sometime later during the first policy year, he/she calls on the insured to renew the policy. But, instead of renewing the insurance, the agent replaces it with a policy from another company. Perfectly legal. The agent replaced the policy for the sole purpose of collecting another first year commission. The difference between first and renewal commissions is incentive enough to encourage the agent to replace. Since the Medicare part A deductible increases each January 1, and all companies amend their policies and premiums at the same time, the agent has a reason to see the insured every year to renew the policy. Once in the door, a replacement is easy. The person who benefits most from this transaction is the agent. Both the insured and the company are victims of this activity. Here's why the insured suffers:

(1) Many policies have a preexisting condition clause. The agent, however, covers this clause by dating the new policy 60, 90, or 180 days prior to the time the existing policy expires. The insured has double coverage during that period, and has paid double premiums during that period. This tactic can be, and is repeated year after

year by the same agent. The agent can earn up to four first year commissions within 2 years, and the insured can pay four annual premiums for Medicare supplement insurance during the same period.

(2) The insured may have had a change in health and may not qualify for the new coverage. The agent can, and sometimes does, answer the questions incorrectly so the policy can be issued quickly, and he can get his money. If the company learns of the action later, and it usually does when a claim is presented, the claim can be denied, and the policy can be canceled.

The company suffers:

(1) When issuing a new policy, the company pays a first year commission to the agent, and perhaps an override commission of 10 to maybe 30 percent to a general agent. When the home office expenses are added to the cost of issue, my best guess would be that it could cost the company up to 125 percent of the first year premium just to issue the policy. If the agent writes with company A in year one, company B in year two, and goes back to company A for the third year, company A has absorbed issue costs twice within 3 years for the same person. It is more profitable for the company to collect the renewal premium and pay 10 percent renewal commission than to reissue the policy.

(2) Agents will usually encourage only the healthy people to switch policies, and avoid those who may be uninsurable. The good risks leave the company, and those who might generate the claims remain. This is known as selection against the company, or adverse selection, and is costly to the company.

(3) Current replacement regulations require completion of a simple form, in duplicate. One copy for the insured, one for the replacing company. The company being replaced does not know about the replacement until its policy lapses, which may be several months following the replacement action.

To discourage, and hopefully eliminate this type of activity, four things must happen:

(1) The financial incentive to replace Medicare supplement policies must be removed.

(2) Companies must take another look at their in-force business, and determine if the same people are written, lost, then re-written at a latter date.

(3) Companies must look more closely at their agents, rewarding them for good persistency (keeping business in force), and penalizing them for frequent replacements that are not in the best interest of the policyholder.

(4) Replacement regulations need fine tuning to become more effective in curbing violations.

I propose the following action to be taken:

(1) Companies will pay the full new business commission to an agent who:

(a) Writes the first Medicare supplement or nursing home policy for a person, or

(b) Writes a Medicare supplement or nursing home policy for a person who has had no coverage of this type in force for 6 months prior to the new policy date. This may

be someone who had a policy, but it lapsed, and he has been without coverage for 6 consecutive months.

(2) Companies will pay the renewal commission if:

(a) The policy replaces an existing Medicare supplement or nursing home policy, or

(b) There has been a policy of the same type in force during the 6 months immediately prior to the new policy date.

(3) Require a replacement form to be completed in triplicate, with one copy each to the insured, the replacing company, and the company who is losing the customer.

If these actions are implemented, the following goals should be accomplished:

(1) The financial incentive for the agent to replace these policies will be removed. A replacement will pay a service fee of 5, 10, or 12 percent, and not 60 percent or more. An agent would not be as aggressive and quick to replace insurance at those numbers. A replacement that is justified will now benefit the insured more than the agent.

(2) The companies should find their operations more profitable, with more policies renewing. And the cost to issue a policy is reduced by, perhaps 50 to 60 percent if it is a replacement policy. The savings might be passed on to the customer in the form of lower premiums.

(3) Companies can track the activities of their agents, who must now notify them if a replacement is pending. Companies can cancel contracts of agents who victimize them by replacement of policies written by the same agents.

(4) Our senior citizens can have a little peace from the constant barrage from health insurance agents. The exploitation of them can cease, and since policies in our State are standardized, they can purchase one policy and stay with it, modifying it as needed, and replacing it only if it is in their best interest.

With that, I thank you for your time and I thank you for this hearing, and I'll be happy to answer any questions.

Senator KOHL. Thank you, Mr. Becker.

Geralyn.

STATEMENT OF GERALYN HAWKINS, MEDIGAP HOTLINE COUNSELOR, WISCONSIN BOARD ON AGING AND LONGTERM CARE

Ms. HAWKINS. The Medigap Hotline is a toll-free telephone number for Wisconsin residents to call for objective, unbiased information and individual counseling about health insurance to supplement Medicare. As a counselor for the Medigap Hotline, I have talked with nearly 25,000 individuals in the past 10 years about Medicare, Medicare supplement insurance, and other forms of health insurance which are marketed to older persons. I am pleased to have this opportunity to share with you some of the problems I observe and concerns that older Wisconsin residents express to me about Medicare supplement insurance.

LIMITATIONS OF MEDICARE SUPPLEMENT INSURANCE

One limitation of most Medicare supplement policies is that their universe of covered expenses is usually identical to Medicare's. Supplements pay benefits for expenses where Medicare has deductibles or co-payments, but seldom do they expand coverage to areas that Medicare does not cover: preventive health exams, prescription drugs, vision, hearing, and dental care, many nursing home and mental health expenses, and medical expenses which Medicare does not consider to be reasonable or necessary. Thus, even with a Medicare supplement policy which the agent assures "will pay everything Medicare does not pay," persons may face significant out-of-pocket medical expenses. Consternation with the shortcomings of this system is especially acute among persons I speak with who report a series of medical expenses where once the claims are all processed, the policyholder pays more out-of-pocket on noncovered expenses than what his or her own supplement paid.

SALES SOLICITATIONS

The methods that some of our less scrupulous insurance agents employ to meet potential customers range from intimidation to carefully calculated approaches which count on the consumer drawing a mistaken conclusion. For example, someone who is told "I have important information I would like to deliver to you about changes in your Medicare benefits" may agree to a meeting, assuming that this individual is acting for Medicare. If questioned, the agent will deny claiming to represent Medicare and blame it on an elderly person's misunderstanding, not remembering precisely, or not hearing correctly, what was said.

Another tactic is to send brief notes to people warning of drastic Medicare benefit reductions or escalating health care costs. The consumer is then encouraged to send for information on an insurance plan that will safeguard them. These letters carry such names as Senior Security Benefit Service or National Association of Retired Persons. The names and addresses collected this way are sold to insurance agents or companies as sales leads. The people expecting to receive further information in the mail instead get insurance agents at their doors. The June 1989 issue of Consumer Reports magazine details problems with lead cards and lack of regulatory oversight and enforcement in many States.

CONFUSING AND MISLEADING POLICY PROVISIONS

A problem consumers encounter in attempting to compare and understand Medicare supplements is confusing and misleading policy provisions.

Here are two examples from Medicare supplements offered in Wisconsin:

In their description of Medicare part B supplementary benefits, Pioneer Life (IMP-9061-A) and United American (MAXC+R188) state that their policies pay all additional covered expenses not paid by Medicare. Many conclude that the policies offer identical benefits. Yet in the definitions section of each policy, a couple of pages removed from the benefit description, a different picture emerges. Pioneer Life defines "covered expense" to mean amounts

not exceeding 180 percent of the Medicare approved figure; while to United American covered expense means up to 140 percent of the Medicare approved figure. A second version of the Pioneer supplement (IMP-9055-A) defines covered expense to be up to 140 percent of the Medicare approved amount. The definitions used are not even consistent within the same company.

In another case where consumers were attempting to compare the part B supplementary benefits of two policies, one policy paid 40 percent of the actual charge—in this case actual charge really means actual charge—and the other paid up to 140 percent of the Medicare approved amount. The conclusion many had reached is that since 140 percent is so much greater than 40 percent, the plan offering to pay 140 percent must have more benefits. However, because policies are paying percentages of different amounts—actual and Medicare approved charges—direct comparison of the percentages is not meaningful. In fact, once benefits are calculated, the policy paying 40 percent of the actual charge pays more than the one offering up to 140 percent of the Medicare approved amount.

In response to these types of problems, the Wisconsin Insurance Commissioner's office revised its standards for Medicare supplement insurance nearly 1 year ago. Confusing policy provisions such as those I described no longer appear in supplements issued after January 1, 1989. Administrative rule INS 3.39 requires policies to use a standard benefit structure which includes an obligatory set of basic benefits and certain uniform additional benefit riders which insurers may elect to offer. These changes simplify benefit comparisons, and enhance the consumer's understanding of policy differences.

This change has been very helpful to consumers and I compliment the Wisconsin Insurance Commissioner's office for implementing it. I would also suggest to this committee that incorporating the idea of uniform benefit standards into the Federal standards for Medicare supplements would enhance the ability of all consumers to make meaningful comparisons of policy benefits, even those consumers who want to compare benefits of a supplement sold in their own State with a supplement offered to them through the mail from another State.

COST

People frequently contact the Medigap Hotline because of concern about costs for Medicare supplement insurance. They are concerned about whether they can afford to continue the coverage but also fear whether they can afford to risk not having a supplement. The single Medicare supplement policy with the largest number of subscribers in Wisconsin, Blue Cross and Blue Shield's Medex-Plus, has seen its rates increase 77 percent from 1986 to what it has announced for 1990. Many consumers assume that the State Insurance Commissioner regulates health insurance rates, much as the State Public Service Commission regulates utility rates. But Medicare supplement rates are only regulated retrospectively. If a policy's loss ratio is less than 60 percent, then the Insurance Commissioner can demand that the company takes steps to raise that ratio. However, in examining some of the disparity in rates for policies

with very similar benefits (see rate comparison attached), I think we need to consider whether there may not be a role for the Insurance Commission's office earlier on in the process. The most striking example of inadequacies in the present rate review system is in the wide range of premiums charged for an additional benefit rider which increases the number of covered home health care visits from 40 to 365 per year. The annual rates for a 65-year-old range from $1 to $395; for a 75-year-old rates range from $1 to $575 per year. This excessive disparity in rates for the same benefit should at least lead the insurance commissioner to investigate whether insurers are interpreting benefits correctly and using sound actuarial principles in pricing the benefit.

This past year when the Medicare Catastrophic Coverage Act increased Medicare benefits and thereby reduced the responsibilities of supplements for certain hospital and skilled nursing facility expenses, many consumers expected lower premiums for their Medicare supplements. But only a small number of policies did lower their rates. Nearly half of the Wisconsin policies increased their premiums. Insurers attributed the lack of premium decreases to the fact that the benefits Medicare absorbed represented only a small part of the total premium. With repeal of the Medicare Catastrophic Coverage Act, insurers will presumably be adding the once-removed hospital and skilled nursing facility benefits back into their policies. Since removing these benefits from supplements did not result in any significant reductions of premiums then, logically, reinstating the benefit should not result in large premium increases.

AGENT COMMISSIONS

Insurance agents earn commissions for selling Medicare supplements. Commissions are a percentage of the annual premium. In Wisconsin, first year sales commissions range from about 15 percent to 75 percent. The commission that the agent earns as the policy is renewed in subsequent years is usually much less than what is earned during the first year. This difference appears to lead some agents back to policyholders after a couple years to replace their coverage. Repeated inappropriate and unnecessary replacements of coverage means income that companies could have applied to paying health care costs or lowering premiums instead goes for the higher first year commissions. Restructuring of commission levels should be explored to remove this built-in incentive for unnecessary replacements.

Dangers for consumers include exposure to new waiting periods before pre-existing health conditions are covered, possibly higher costs due to purchasing at higher ages; and possibly reduced benefit levels. After purchasing the replacement policy, the surprise waiting for some is the discovery that their initial insurer ignores their cancellation request and refuses to refund the balance of their premium. The only time Wisconsin laws require refund of a Medicare supplement premium is during the 30-day free look provision following receipt of the plan. In fact, for a Wisconsin Medicare supplement policyholder who dies in March after having paid an

annual premium January 1, all they can depend on is the goodwill of the insurer to refund the balance of the premium.

CLAIMS

For those who have survived or avoided problems with benefit limitations, confusing policy provisions, and costs of Medicare supplements, another trial may be filing and collecting a Medicare supplement claim. Some companies appear to put obstacles into the claims filing process which serve no purpose other than discouraging the policyholder from pursuing a claim. For example, there are policies which pay 20 percent of Medicare-approved amounts on Part B, but require an itemized bill to be submitted in addition to the Medicare explanation of benefits form. The claim is not paid if the itemized bill is not included, even though the explanation of benefits from Medicare clearly shows what amount has been approved.

DISABLED MEDICARE BENEFICIARIES

Often overlooked in the Medicare supplement area is the disabled Medicare beneficiary—a recipient who is entitled to Medicare before 65 due to receiving Social Security disability benefits. The gaps in Medicare are the same for those under 65 as for those 65 or older. But the great majority of Medicare supplement plans are offered only to persons 65 or older. For many disabled Medicare recipients the best route to additional health insurance coverage is simply to remain with the health insurance they carried prior to becoming Medicare-eligible. However, many are disappointed to find that once they are eligible for Medicare and have Medicare as their primary insurer (which greatly reduces the insurer's liability for many expenses, such as hospitalization), their health insurance premium does not change. In fact their health care expenses increase because now they must also pay the Medicare Part B premium. Discontinuing Part B is not an option in many cases because policies include clauses stating that if the insured is eligible for Medicare, policy benefits will be paid as if the person has Part A and B of Medicare, whether they are actually enrolled or not.

What I have presented here is a summary of some of the concerns that consumers voice to me about Medicare supplement insurance. I appreciate the committee's timely interest in this area—the passage and subsequent repeal of the Medicare Catastrophic Coverage Act compound the omnipresent confusion about Medicare and puzzlement with Medicare supplement insurance.

Thank you.

COST COMPARISON CHART FOR SELECTED INDIVIDUAL MEDICARE SUPPLEMENT POLICIES APPROVED FOR SALE IN WISCONSIN*

prepared by: Center for Public Representation and
Medigap Hotline of the Wisconsin Board on Aging and Long-Term Care

Premiums listed are for policies for a female living in Milwaukee with basic coverage of seven required benefits PLUS additional benefits of Medicare Parts A and B deductibles and 365 home health visit options. All of these policies pay the 20% of Part B expenses.

	65 years old	75 years old
American Family Mutual Insurance Company	$ 391.70	$ 510.00
Wisconsin Physicians Service Insurance Corp.	$ 586.80	$ 586.80
State Farm Mutual Automobile Insurance Company	$ 464.60	$ 658.00
Bankers Life and Casualty Company	$ 504.32	$ 816.62
United American Insurance Company	$ 825.00	$ 880.00
Blue Cross & Blue Shield United of Wisconsin	$ 961.62	$1,017.51

*Source of Information: Office of the Wisconsin Commissioner of Insurance Medicare Supplement Policy Chart, July 1, 1989.

COST COMPARISON CHART FOR SELECTED INDIVIDUAL MEDICARE SUPPLEMENT POLICIES APPROVED FOR SALE IN WISCONSIN*

prepared by: Center for Public Representation and
Medigap Hotline of the Wisconsin Board on Aging and Long-Term Care

Premiums listed are for policies for a female living in Madison with basic coverage of seven required benefits PLUS additional benefits of Medicare Parts A and B deductibles and 365 home health visit options. All of these policies pay the 20% of Part B expenses.

	65 years old	75 years old
American Family Mutual Insurance Company	$ 391.70	$ 510.00
Wisconsin Physicians Service Insurance Corp.	$ 586.80	$ 586.80
State Farm Mutual Automobile Insurance Company	$ 464.60	$ 658.00
Bankers Life and Casualty Company	$ 504.32	$ 816.62
United American Insurance Company	$ 825.00	$ 880.00
Blue Cross & Blue Shield United of Wisconsin	$ 804.00	$ 957.06

*Source of Information: Office of the Wisconsin Commissioner of Insurance Medicare Supplement Policy Chart, July 1, 1989.

Senator KOHL. Thank you, Ms. Hawkins. Mr. Cullen, as you look at the various costs on the basic policy that we have on this chart, do you have any comments to make? I mean, this is a basic policy, which I understand is very common and prevalent, but all these different varieties of costs—what do you say to a consumer, Mr. Cullen?

Mr. CULLEN. First of all, I would say to them, "Your chart is inaccurate as it relates to my company on two counts: the age 65 rate and the age 75 rate."

The second thing is that my company sets rates by sex and by region of the State, so by choosing to show a chart of females living in Milwaukee, that's the highest category rate Blue Cross and Blue Shield charges. If you were going to show the rate for people in Mount Horeb or Eau Claire they would be much less. Whereas, the other large companies have a uniform rate across the State.

So, for the record, I will make those two points about the chart.

The other point is senior citizens ought to buy based on value. I think it is important to know where a company's rates are over a period of several years. That's the kind of thing the senior citizen and an agent, one-on-one at a kitchen table, are never going to resolve in the interests of the senior citizen.

I think where there's a marketplace there are three agents in the kitchen at the same time. In that situation the senior citizen might have a chance to do okay, but that never occurs to my knowledge. In most situations it's one agent and one senior citizen and, therefore, there really isn't a marketplace.

So, my response is government ought to say, "There's one policy. These are the benefits. Any company that wants to sell it, they can sell it."

Then, the senior citizen knows no matter who they buy it from they're getting the same level of benefits and they let the company figure out what price they're going to charge.

Senator KOHL. So, if you were in a position to mandate a resolution of what we're discussing here this morning you would say, "Let's have a governmentally endorsed, approved policy, the benefits of which are the same no matter which company markets it." The senior citizen understands clearly that that's the policy and they can price it out as they wish between all the different companies.

Does anybody disagree with Mr. Cullen on that?

Mr. HASSE. That's what we're now doing. There will be one basic policy and there are other coverages a person might want which will be sold by rider with a price tag on them.

This will be done all over the United States. This is what the NAIC has adopted and the Federal Government wanted us to adopt. And that is a basic policy and anything else you want to add to it will be done by a rider and you pay for it.

Senator KOHL. Mr. Becker, do you have a comment on that?

Mr. BECKER. I'm concerned with riders because they're confusing. I'm grateful that Wisconsin does have a uniform policy and I would like to see a national policy basically because Medicare is something that is federally mandated, it's there, and so, the policy should be the same.

I believe that companies can learn how to operate efficiently and decide how they're going to price them; they can decide how they want to market it and the cost of marketing and so forth. I agree with the Federal policy.

Senator KOHL. Ms. Hawkins.

Ms. HAWKINS. If you're envisioning the Federal Government coming out with just one package of benefits—no riders, simply one package—I think before we could get to that point the Federal Government has to deal with the Medicare Part B issue of the difference between Medicare approved amounts and what people are actually being charged. If you mandate a Medicare supplement plan that is Government endorsed and will pay 20 percent of what Medicare approves, and yet, we still have a zillion providers out there who charge more than what Medicare approves, then you'll have many consumers wanting to buy something that pays more than just the 20 percent to cover themselves for the gap in Medicare's approved charges and the actual charges.

I am familiar with the system we are using here in Wisconsin and if it is going to be adopted nationwide I would welcome that. We have had limited time to work with it here in Wisconsin—just this past year—but my perception is that it is going pretty well.

We limit the number of possible riders the companies can offer. They can not just dream up everything and anything and say, "We sell this as a rider. Does your Medicare supplement?"

We have identified for insurers approximately half a dozen riders that can be offered with a policy and have told companies, "If you are going to offer rider No. 1, rider No. 1 is the same benefit whether you are buying it from Blue Cross, United American, or whoever. This system allows people to make direct benefit comparisons, which allows the price comparisons to be meaningful.

Senator KOHL. Tim Cullen, would you support rate approval by States?

Mr. CULLEN. Yes.

Mr. HAASE. Are you talking about prior approval?

Senator KOHL. Yes.

Mr. HAASE. It doesn't work.

Senator KOHL. You would not support it?

Mr. HAASE. I don't support it. I got rid of it and I'm pleased we did. We have, I think, quite a bit of rate control here when you start regulating the the commissions with the level of commission thing, when you say you have to have at least a 60-percent loss ratio, you've gotten over all these silly arguments—"What's the trend factor?" et cetera.

If you don't think 60 percent is high enough then it can be raised to 70 percent. I don't have a problem with that.

And another thing is, in an election year how much rate increases do you think you're going to get when needed?

Senator KOHL. What about these companies who consistently fall below the loss rate?

Mr. HAASE. If they fall below the loss rate consistently we require them to refund the money or increase the benefits without premium increases. With anybody who consistently falls below they have to show us how their rate is going to get to the 60 per-

cent. We would be working with them to either reduce premiums or else increase their benefits.

Senator KOHL. I'm not sure I'm a hundred percent correct but we have several—Wisconsin Health at 30 percent loss rate, American Family Life at 27½?

Mr. HAASE. OK, I'll tell you what that is. American Family Life was 46 percent last year; they have a very little bit of premium. They had less than $1 million in premiums last year, so they will be getting it into shape this year.

Senator KOHL. HMO Midwest—24 percent?

Mr. HAASE. Again, you're talking about HMO's. I have many problems with the way HMO's function; they're difficult to deal with. Again, they only have $15 thousand in premiums. It's not credible to say to them, "You've got to have a 60 percent loss ratio of premium."

Senator KOHL. So, you say that the cooperation between the insurance companies operating in this State, in your experience, has been good and sufficient in all cases so that you've never had to revoke a license?

Mr. HAASE. I can't answer that. I don't know. I was Commissioner so many years ago the first time I don't know. I'm sure somewhere along the line we have revoked licenses, yes.

Senator KOHL. Mr. Becker thought we should be doing more about revocation.

Mr. HAASE. We revoke a lot of agents' licenses very frequently.

Senator KOHL. You do?

Mr. HAASE. Yes.

Senator KOHL. Mr. Becker, do you have a comment on that?

Mr. BECKER. Well, frankly, I've seen revocations for violations far less in my estimation than the ones that are printed in your bulletin. Contrary to what one of the gentlemen said, Mr. Keeling, I believe you can't always sell insurance; I really believe that marketplace demands a professional, and some people who do graduate with a bachelor's and master's degree are going into the insurance business, believe it or not.

I can't say I'm in the company of the true professional public-serving people. However, to make the case that to revoke a license means to eliminate someone's livelihood is hogwash; I think it's totally hogwash and when people are out gaining the trust of unsuspecting senior citizens who want so desperately to have some help. Agents have gone to far more "how to get people's trust" seminars than they have product seminars.

Perhaps on the horizon is a continuing education requirement for agents. I believe agents ought to pass standards; I believe they ought to have these standards updated.

For this gentleman in this case it was his second violation within 2 years. It was the second fine, the second suspension, and he'll be on the streets January 15, and you can bet your boots the same thing is going to happen unless the incentive is taken out of it, and I don't see that happening shortly. And I see our Office receiving phone calls from many of our clients saying, "What is this person doing in our home?"

Senator KOHL. Mr. Haase, I would like to ask you a question. What would you say to Mr. Halfin, who's an experienced man over

many, many years in the field, and who said to us today that the incidence of abused consumers is huge and they're not in a position to make the kinds of judgments based on no experience that benefit them. As the Insurance Commissioner what would you say to Mr. Halfin?

Mr. HAASE. My answer is one, is "too many." And going back a few years, that's why we went in Wisconsin to a three-tiered system of Medicare supplement policies. Nobody could understand them. People were selling cancer policies and Medicare supplement policies. So, we put together three definite specific policies; you had to sell one or the other.

But now I think it works better to have a simplified procedure. If in fact agents are violating this and it comes to our attention we will take action. Our problem I think is that older people don't really like to get involved—and I realize this is part of the problem—they don't like to get involved in this big mess that's going to take place. They're afraid, they're insecure, and they're not ready to call up and say, "This guy just cheated me." If they do that we will take action.

Senator KOHL. Mr. Halfin, if you had to respond to Bob today, what would you say?

Mr. HALFIN. I agree with him—once we get the person to contact the insurance commissioner's office—but it's that education he talked about. They won't pick up the phone and call. I've given the number to a person to call, and I go back and say, "Did you call?" and the person will say, "No."

There's something, they just don't want to do that for some reason.

I'll pick up the phone and call for them or write a letter for them and have them sign it. And, Ms. Hawkins, I commend you for what you do, because if I can't get them to call I would call Ms. Hawkins to help with it.

And I can't complain about the insurance commissioner's office, however, we do need to educate the seniors out there on how to buy or what to do with Medigap insurance. It's a mammoth problem and rural Wisconsin is really hurt because you have this farm lady right here with a half a mile of nothing on either side of her and she's vulnerable for that agent because she's lonely and she wants to talk to somebody.

I don't know whether I've responded to him or not.

Senator KOHL. Thank you. Any other comments anybody would like to make?

Mr. HAASE. Just that I would welcome any suggestions you might have as you study this as to what we can do here. I think we're all in the same boat, not one government and another.

Senator KOHL. Somebody suggested that there be a 7-day waiting period before someone could finalize that policy and during that 7-day period that the policy should be sent somewhere for someone to authorize.

Mr. HAASE. If you can find the "somewhere" I have no problem with that. We do right now have a law that says you have 30 days after you get the policy to reject it. We'll look at it; its not a bad idea.

Senator KOHL. Tim, do you have a comment to make regarding that suggestion?

Mr. CULLEN. I think it's great. Fundamentally, I think when you try to put band-aids on this problem you have to eliminate the need to have agents in the farmhouse with the senior citizen one-on-one. We can change that if the policies are sold through organizations such as the Coalition, providing uniform policies or, of course, closing the gaps of Medicare.

Also, I think Ms. Hawkins alluded to a separate but very related issue which is the issue of physicians accepting Medicare assignments. We're talking about how much a policy covers, 100 percent of this or 40 percent of that.

That is all driven on whether or not a physician accepts Medicare assignments. Some physicians do, some don't. It's a huge issue. It's an issue for both the State and Federal policymakers.

If all physicians accepted Medicare assignment a lot of this goes away.

Senator KOHL. Well, it's been a great panel. I want to thank you all for coming. You've been very helpful, very informative. Thank you.

We'll call our last panel. We have Betsy Abramson, the director of the Elderly Department Center for Public Representation in Madison, and Bette Johnson, president of the Coalition of Wisconsin Aging Groups. Folks, we look forward to your testimony and a few questions. Betsy, go ahead.

STATEMENT OF BETSY J. ABRAMSON, DIRECTOR, ELDERLY DEPARTMENT, CENTER FOR PUBLIC REPRESENTATION

Ms. ABRAMSON. Thank you.

The Center for Public Representation appreciates the opportunity to present testimony to your committee today. The Center is a nonprofit, public interest law firm, representing the rights of traditionally unrepresented and underrepresented individuals and groups, including the elderly, health care consumers, families, and women. We have extensive experience in Medicare supplement issues, through the operation of our lay advocate legal assistance program for the elderly, known as the benefit specialist program in Wisconsin, as well as our national training contract on these and other issues with A.A.R.P.

I have been asked today to suggest areas for Federal action in Medicare supplement legislative and regulatory reform, and I am pleased to do so. I find it encouraging, first and foremost, that your committee is recognizing that the Federal Government's long-standing deference to the States on matters of insurance can no longer be tolerated, at least in the area of Medicare supplement insurance. Medicare supplements are, of course, tied to Medicare—the Federal Government insurance program and, given Congress' constant changes to the Medicare Program—nowhere more painfully evidenced than the on-again, off-again catastrophic program—the Federal Government must take the lead in regulation of the Medicare supplement insurance market.

I would like now, to identify 10 problem areas that we have noted in Wisconsin over the years and proposed solutions for your consideration.

(1) Inappropriate replacements—The changes resulting from Congressional action on the catastrophic program have only exacerbated the long-standing problem of unscrupulous agents making inappropriate replacements, which results in beneficiaries being subject to higher premiums, new underwriting conditions, and new waiting periods for pre-existing conditions.

Proposed solution.—The Federal Government must put limits on the first-year commission to agents, which we believe is the main motivator of these sales. Additionally, there must be strong regulations on suitability, including the replacing company sending a notice to the current insurer, and stiff penalties for violations.

(2) Out-of-State marketing abuses.—State governments have little or no control over the type of celebrity endorsement and invitation to toll-free phone line types of television pitches, which result, in our experience, from consumers often purchasing on their own excessive numbers of policies.

Proposed solution.—The FTC should be given regulatory authority over this area and should develop regulations which restrict the use of toll-free phone lines and require such companies to comply with the replacement rules of the State in which they are marketing.

(3) Mid-policy term right to cancellation and refund.—Many companies require 3, 6, or even 12 months' premium at one time, and then refuse to refund any prepaid premium when a policyholder cancels during the policy's term.

Proposed solution.—Federal law should require companies to refund consumer premiums upon 30 days' notice of cancellation by the insured.

(4) Gross rate disparities.—As the charts you have already seen demonstrate, companies selling the same policy have rates varying by over 200 percent. The percentage of premium increases each year also clearly demonstrates the need for improved rate regulation. This issue, too, has been heightened by catastrophic: Last year at this time, companies told us that "catastrophic wasn't adding that many benefits" so their policies still would increase, although not quite as much as they otherwise would have. This year, the New York Times, October 25, 1989 reports, and Wisconsin experience confirms, that insurers assert that, with the repeal of catastrophic and the burden of these benefits being returned to the Medigap insurers, premiums will increase by, in some cases, as much as 76 percent. Without meaningful rate regulation, some insurance companies appear to be making a huge profit on the backs of some understandably confused Medicare beneficiaries. In Wisconsin, we have no rate regulation, other than use of a loss ratio—companies are to pay out $0.60 of every $1 collected. We do not believe the Wisconsin Insurance Commissioner is adequately enforcing this.

Proposed solution.—The Federal Government should require State insurance commissioners to vigorously enforce loss ratios, applying it to each benefit (where benefits are provided by riders),

publicizing annually the loss ratios for each of these companies, and requiring annual notice to each policyholder.

(5) Nonstandardized benefits make cost comparisons impossible.—Wisconsin has made important strides in this area in the last year by requiring a standard basic policy, with additional benefits to be provided by rider. This has greatly reduced the "comparing apples and oranges" problem.

Proposed solution.—The Federal Government should make such standardization mandatory in all States.

(6) The continued sale of dread disease and indemnity plans results in consumers' spending limited dollars for health care inefficiently.—The purchase of "cancer insurance" and hospital indemnity policies is, in almost all cases, duplicative of Medicare and therefore, a waste of premium dollars.

Proposed solution.—The Federal Government should follow the lead of several States in banning their sale.

(7) Poorly trained agents' sales pitches misinform the public.—A Medigap agent MUST possess an extensive knowledge of both Medicare and Medicaid law in order to competently and accurately present a Medigap policy's value to a consumer.

Proposed solution.—The Federal Government should require specialized initial, as well as continuing education training for agents in this area. State insurance commissioners should be required to develop and conduct these training programs so as to both avoid putting this responsibility on companies, and to ensure accurate, consistent information.

(8) Lack of consumer education continues to be a major problem resulting in poor insurance choices by consumers.—Wisconsin is also is the forefront in this area by having developed consumer brochures (with required agent distribution), comparison charts available to the public, and a toll-free Medigap Hotline staffed by knowledgeable, objective counselors.

Proposed solution.—Such initiatives should be required by the Federal Government in every State. The "Medigap Hotline" should be funded by a small tax on agents.

(9) State enforcement and complaint-handling is inadequate.—Unfortunately, Wisconsin is a good example of a State in need of improved enforcement and complaint-handling. Our insurance commissioner, and those of other States, must have the authority to make individuals whole, by returning premium dollars and requiring payment on inappropriately denied claims. Consumers must be given a clear private right of action under the insurance code, and consumer protection laws must not exempt insurance. Toll-free complaint lines must be staffed by consumer-friendly, real people, and enforcement efforts must show the public that more than wrist-slapping is going on.

Proposed solution.—The Federal Government should require toll-free complaint lines in every State, should make clear that all consumer protection laws apply with full force to insurance matters, should establish a private right of action for consumers, and should enact systematic, clear standards for penalties for violations. Regular publication of insurance department enforcement efforts should be made to the public, and copies should be sent to the State-funded Medigap Hotline.

(10) Mandated benefits are in some cases only phantom benefits.—In coverage areas where Medicare does not have the traditional "cost gaps," Medigap coverage must, by definition, provide more generous coverage (i.e., less restrictions/conditions for coverage) or the benefit will be meaningless. An example of where we believe such is currently the case in Wisconsin is home health care.

Proposed solution.—The Federal Government must carefully look at mandated benefits and provides State, with the directive, and tools, to ensure that such benefits are actually paid out. Some ideas include, selected claims review by the State, enforcement of the loss ratios on the benefit, review of policy criteria, and strengthened regulation.

I would be happy to answer any questions the committee might have regarding my testimony, and again, I wish to thank the committee for its invitation to participate today.

Senator KOHL. Thank you, Ms. Abramson.

Ms. Johnson.

STATEMENT OF BETTE M. JOHNSON, PRESIDENT, COALITION OF WISCONSIN AGING GROUPS

Ms. JOHNSON. Thank you for this opportunity to testify at this very important hearing.

My name is Bette Johnson and I'm president of the Coalition of Wisconsin Aging Groups.

The Coalition of Wisconsin Aging Groups is an organization of 587 groups representing thousands of older adults. I feel the Coalition is the voice of Wisconsin's elderly. When we get together, what we hear most about is health, that is, maintaining a state of health that will avoid an involvement with the Medigap supplemental insurance mess. And a mess to them it is—confusing Medigap supplemental coverage and, if they do understand it, the majority are not able to afford the astronomical rate. Is this then a compassionate way to treat Wisconsin's and the Nation's elderly; these people who have given so much of their talent, time, and energy to help build a great country? Many Members of Congress refer to these folks as those people in their golden years. The Coalition of Wisconsin Aging Groups agrees with them and will be, as we always are, watchful of the State of Wisconsin's role in the Medigap supplemental insurance.

It is so easy to prey on the fears of the elderly regarding inadequate health care coverage; an indiscriminate salesperson has an easy, quick sell. We must have State and Federal laws regulating protection for these older people. To my knowledge, there is nothing at present to address this problem. With the integrity the State of Wisconsin has shown in the past regarding regulations and laws protecting the elderly, I am confident the State will address the problem. However, all States do not have the same attitude our State has; therefore, we must have Federal laws for the same protection. We repeatedly hear about older people who have been at the mercy of salespersons who have used fraudulent means to sign up people for Medigap supplemental insurance through scare tactics.

This generation of Americans believes in the celebrities they grew up knowing so well. They put their faith and trust in these celebrities. Now, some of us feel this is foolish, but many older people believe celebrities like Art Linkletter, James Roosevelt, and others would never sell them a lemon. Again, foolish though it is of these older people, where is the credibility of these celebrities who sell a less-than-honest product, including Medigap supplement insurance, that is clearly geared toward an elderly market.

We in the Coalition of Wisconsin Aging Groups are proud of our efforts as advocates for Wisconsin's elderly. We recognize the elderly people's concern, not only for their children and grandchildren, but all children and grandchildren. Why then do we continue to approach the major health problem in our State and country with band-aid solutions? What we need desperately is a health care plan that will care not only for the elderly, but the children, grandchildren, and the millions of uninsured people in this country.

The recent enactment and then swift repeal of the catastrophic program stands as clear proof that the piece-meal approach to health care for the American citizenry will not work. Catastrophic failed because it offered a few benefits to only one segment of the population and asked that one segment to bear the entire burden of it. Medicare's popularity these almost 25 years, however, has been rooted in its social insurance structure and its universal eligibility. We all (young and old) pay in so that the elderly and disabled—our parents now and ourselves in the future—will have this protection. The American public wants such a program of national health care for all citizens now, young and old now, one that we all pay into and all are eligible to use as we need it. Parceling out this government responsibility to insurance companies will leave us with another form of the Medigap mess. Let us learn from our experiences these last 20 plus years: The Government must firmly take the lead.

What is the principal role of Government? Government is the servant of the people, to do for the people what they cannot do for themselves. A wise old friend once told me that "when all is said, nothing is done." Senator Kohl, I would ask you and your colleagues on the U.S. Senate Special Committee on Aging to accept the challenge of becoming the leadership toward providing a universal health care plan for all citizens in our country.

COMPARISON OF SELECTED INDIVIDUAL MEDICARE SUPPLEMENT POLICIES APPROVED FOR SALE IN WISCONSIN*

Premiums listed are for policies for a female living in Milwaukee with basic coverage of seven mandated benefits plus additional benefits of Medicare Parts A and B deductibles and 365 home health visit options.

POLICY	Age 65	Age 75	1st Year Commission to Agent
American Family Mutual Insurance Company	$391.70	$510.00	18.75
Wisconsin Physician Service Insurance	$586.80	$586.80	15
State Farm Mutual Automobile Insurance	$464.60	$658.00	18
Bankers Life and Casualty Company	$504.32	$816.00	35/25
United American Insurance Company	$825.00	$880.00	60
Blue Cross & Blue Shield United of Wisconsin	$961.62	$1017.51	$3/mo.
Pioneer Life Insurance Company of Illinois	$928.00	$1247.00	67.5
Colonial Penn Life Insurance Company	$1150.00	$1510.00	75/65

*Source of Information: Office of the Wisconsin Commissioner of Insurance Medicare Supplement Policy Chart, July 1, 1989, and Wisconsin Insurance Report, Robert D. Haase, Commissioner of Insurance, Business of 1988, p. 118.

TABLE II
DOES THE STATE REQUIRE THAT MEDIGAP PREMIUM INCREASES BE FORMALLY APPROVED BEFORE GOING INTO EFFECT?

STATE	INDIVIDUAL POLICIES		GROUP POLICIES	
	YES	NO	YES	NO
Alabama		X		
Alaska				X**
Arizona	X			
Arkansas	X			X*
California		X	X	
Colorado	X			X**
Connecticut	X		X	
Delaware	X		X	
Florida	X		X	
Georgia	X			X
Hawaii				X
Idaho		X		
Illinois	X			X
Indiana	X		X	
Iowa	X			X
Kansas		X	X	
Kentucky	X			X**
Louisiana		X		X**
Maine				X
Maryland		X		
Massachussetts	X			X**
Michigan	X			X
Minnesota	X			X**
Mississippi	X			X**
Missouri	X		X	
Montana		X	X	
Nebraska				X
Nevada				
New Hampshire	X			
New Jersey	X		X	
New Mexico	X			
New York	X			X*
North Carolina	X			X*
North Dakota				X**
Ohio	X			
Oklahoma		X		X**
Oregon	X			X
Pennsylvania	X			X**
Rhode Island	X			X**
South Carolina	X		X	
South Dakota	X			X**
Tennessee	X		X	
Texas		X	X	
Utah	X			X**
Vermont	X		X	
Virginia	X		X	
Washington	X			X**
West Virginia	X			X
Wisconsin		X	X	
Wyoming		X		X
Dist. of Columbia		X		X**
				X
TOTAL	32	12	16	28

* A limited number of group policies are reviewed.
** Group Medigap policies do not even have to file (inform) the State of changes in premiums. (15 States)

Senator KOHL. That was a very fine statement, Ms. Johnson. I appreciate it very much.

Betsy, on the issue of loss ratios would you agree with the argument put forth by the Commissioner? In your opinion are they being enforced, and in the event the States are negligent in that enforcement, what Federal leverage would you suggest? Would it be levied against the State or against the firm itself?

Ms. ABRAMSON. I was intrigued by Commissioner Haase's answers to your questions. For every company that you put out he had a separate excuse. One "hadn't had enough years of experience" and a couple" hadn't enough premium collected" and another one was an HMO and, "We all know about HMO's."

What I go by is looking at the numbers, that is, the premiums. As I said, it seems incredulous to me that each company could possibly be in compliance with the loss ratios when the premiums differ so much. I also question whether this loss ratio check, retroactive check, is actually being made on both the base and the loss ratio. It can't possibly be.

A company who sells a separate rider for the $75 part B deductible for a cost of $79 couldn't be paying out all they should on that benefit, so I don't believe it's being enforced in Wisconsin.

As to how it should be done, I do tend to agree that I'm not sure rate regulation is the way we should go. First of all, Geralyn pointed out the example of rate regulation in public utilities, and we certainly know in this State that for consumers to try to go to those rate hearings and crunch out numbers as speedily as the industry's 15 number-cruncher experts do would be impossible.

I think the Federal Government needs to get serious about rate regulation. For instance, I noticed in Commissioner Hasse's testimony that he stated one of the reasons rates haven't been going up in Wisconsin is that we have been imposing our loss ratios for years and other States are just beginning this.

So, I guess the answer to your question is, "No." I don't trust that States are enforcing the loss ratios on their own if they just happened to notice that compliance with loss ratios has been required for 7 years. So, I do think that the Federal Government needs to get behind that and push at that more.

As to the whole other bigger issue of rate regulation, I'm not prepared for consumers having to go toe-to-toe with the industry in justifying rates because I think that's a losing proposition for consumers. I do think that simply requiring companies to file their rates before they use them is notice by the companies to the Commissioner. And if I was in the Commissioner's office it would certainly make me wonder how there could be this huge rate disparity in identical policies, and I would start to do some checking up on this.

Senator KOHL. Is your concept of the Insurance Commissioner's Office in this State or in any State an office that should coequally represent both business and the consumer or just the consumer or just the business?

Ms. ABRAMSON. Coequal.

Senator KOHL. Coequal. And that should be the proper role of representation, coequally business needs and consumer needs?

Ms. ABRAMSON. I'm not so naive as to think that consumers aren't benefiting from companies staying solvent, so I'm not suggesting that companies all be required, for example, to charge premiums of no more than $150 if they're all going to go bankrupt and consumers are left with no insurance.

So, I think there is a tie-in in looking out for the interests of business. This will be helping consumers as well, but I think their primary goal should be looking at it from the consumer end.

Senator KOHL. OK. Bette Johnson, I'd like to assure you that there are both Federal and State policies for fraudulent marketing of Medigap policies. A Federal law has been on the books since 1980, but according to the GAO it has not been enforced.

One question—how can we do a better job of enforcing the laws that are already on the books? Do you have any comments to make on that?

Ms. JOHNSON. Yes, I do, Senator Kohl. The one thing that I particularly think we are so fortunate in the State of Wisconsin to have is our Elderly Benefits Specialist Program. I think these people are very helpful. They're educated, they're informed, and they are such an aid for elderly people and they will know those hard, sticky, confusing questions that older people have. They are well informed and they can inform the people.

And I think that we in the Coalition of Wisconsin Aging Groups have been very supportive of this program. In fact, we advocated and we worked very hard in the assembly and in the State Senate and with the Governor to further fund the program, and I would say that this would be something that has to be continued.

The misinformation and the lack of good information, as we have heard this morning—even with the Elderly Benefits Specialist Program we have folks that hesitate to make this call. People don't like to be looked at as kind of a little bit stupid, and they hesitate to make the call.

And we need to do more education, too. We need to make the older people aware that Elderly Benefits Specialist Program is out there to help them. And it isn't difficult to say, "I don't know"; I say it all the time.

And I think that we are very very fortunate to have that in place, and I think as an advocacy group, as we are in the coalition, we will continue to work with informing older people of the benefits of the Elderly Benefits Specialist Program, and I would hope that they will be able to continue to work as well in the future as they have in the past.

Senator KOHL. Very good. Well——

Ms. ABRAMSON. If I could just add one thing—I think it's two things.

First of all, as Mrs. Johnson points out, many people are reticent to come forward and make complaints. I think that's the "Gee, how could I have been duped?" syndrome.

And, also, people who have been through the complaint process with the Commissioner before figure, "Is it worth it? If I'm not going to be able to get my premium back or will not be made whole, how will it help?" and the answer being, "Maybe you'll help the next person who gets duped by this agent."

Second, I think OCI should be required, on a quarterly basis, for example, to relay information to the Medigap Hotline so the public is made more aware of it. Right now if an individual wants to, he or she can write to OCI and find out the numbers of complaints that have been filed against a company, but unless they go over and look through all the files they can't track those files and find out how many ultimately resulted in any enforcement.

Senator KOHL. Thank you. Well, you comprised a really great panel. I very much enjoyed having you here. It was well worth it for us, and thank you for coming.

Mr. JOHNSON. I have in here a packet of material describing the Coalition of Wisconsin Aging Groups. I am always selling the Coalition of Wisconsin Aging Groups, and I'd like you to know more about it. We all would thank you again.

Senator KOHL. Well, we have had an excellent hearing, folks. There's a lot of information on the table and a lot of work that needs to be done. And I want to assure you that my office will do everything that it can to follow up on the information we have heard today and to see that we effect improvements on what clearly is a very serious problem in our State and in our country.

[Proceedings were concluded at 12:20 p.m.]

APPENDIX

Item 1

Testimony of James T. Sykes,
for the National Council on the Aging,
before Senator Herbert Kohl, Member,
Senate Special Committee on Aging
December 11, 1989

Senator Kohl, I am James Sykes, Chair of the National Council on the Aging's Public Policy Committee, and the founder of a successful community based long-term care system in Wisconsin. I teach in the Medical School at the University of Wisconsin-Madison. I mention these three roles because in each I have witnessed the need for a national policy on long-term care which ensures that all persons of every age facing chronic illness have access to comprehensive, affordable, quality care.

You have come to Madison to take testimony on the Medigap insurance situation. While there are many steps that can be taken to correct problems within the Medigap industry, we believe that the problem for which Medigap insurance is an "answer" is so systemic that only a comprehensive, national policy on health care--including especially long-term care--will work for the citizens of America.

The time is now for a truly comprehensive national policy on health care for all citizens. Stop-gap measures, tinkering with Medicare or Medicaid to add limited services for those who need care--in their homes or in institutions--with minimal funds, simply will not do. The mandate of this Commission demands a dramatically new approach to health care in America, for those who suffer the consequences of double jeopardy, serious illness and the fear of impoverishment due to the cost of care.

These consequences affect the families of those in need as surely as they do the individual. Indeed, the entire community pays the price of a system that works for some, but not others, covers certain illnesses, but not others, and provides options for some, but institutionalization and impoverishment to others.

The NCOA concurs with the direction of the findings of the Joint Economic Committee's Subcommittee on Education and Health that "National health insurance, modeled after the Canadian approach, would ensure all Americans access to high quality, affordable health care," that "standards of care based on outcomes research must be developed and applied by the health care community to limit unnecessary tests and procedures," and that research priorities must be changed. Health promotion and disease prevention and problems afflicting the elderly, such as arthritis, dementia and incontinence, must receive greater attention."

We find the words of Wisconsin's Bureau on Aging Director, Donna McDowell, precisely on target. She wrote that our long term care efforts carry the "scent of failure."

"Failure of a caregiver to be durable over the long haul.

"Failure of a long term care system to provide acceptable, affordable care.
"Failure of a government to finance the care of its chronically disabled citizens.
"Failure of a mental health system to respond to chronic mental illness.
"Failure of an economy to sustain adequate employment and retirement income.
"Failure of a marriage, of a parent.
"Failure of a social worker to "fix" a bad scene.

The failures, Mr. Chairman, are ours. Benign neglect, on the one hand, and over-reliance on a patchwork system of private out-of-pocket spending and Medicaid, on the other, must be replaced by a comprehensive national health care system.

We have the capacity to correct these failures. Repeatedly, polls have shown that we want a sensible, affordable, quality health care system; and, those same polls show, we're willing to pay for it through our taxes rather than facing directly the high costs of long-term care. We need political leaders--with the vision and commitment of Claude Pepper--to put us on a course toward a national health system, based on a flexible social insurance model. Only such a system can provide the framework for efficiency and universality.

We need to expedite the national dialogue on such a system now or the catastrophic "Medicare crisis" and the scandal of millions of citizens lacking health care protection will become mere symptoms of a more profound economic and political crisis in the decade ahead.

I've read the testimony which the Pepper Commission has received. While the NCOA supports many of the recommendations contained in the testimony--and could provide hundreds of examples of what neglect and reliance on a means-tested patchwork non-system costs our elders, their families, and others in need of health care--I would like to draw your attention to three problems calling out for solution.

"The need to build the service infrastructure in neighborhoods and communities to provide options and support to vulnerable individuals and their families.

"The need to enable elders to continue to live where they prefer, in special places--elderly housing, group homes, continuing care retirement communities, and naturally-occurring retirement communities.

"The need to recruit and train professionals, managers, chronic care workers and volunteers to provide the care and support essential to a health care system that works for all.

Only within the framework of a comprehensive, universal national health care system can these--and countless other problems--be properly addressed.

Such a system will make long-term care an integral part of a comprehensive national health care entitlement--a goal the NCOA has advocated over many years. We recognize that an individual's physical and mental health demand appropriate attention, and that chronic care as well as acute care must be provided to all in need--not just those in nursing homes or hospitals.

In fact, we believe that for most persons care should be delivered to where one lives not the other way around with the ill transferred to facilitate providers or to simplyfy administrative process. We know that attention must be given to both the one directly in need of intervention and support and the providers of care. The NCOA affirms that the individual must be at the center of every care plan, controlling and sharing responsibility for his or her care.

Such a national policy must be grounded on principles such as the following, developed and approved by the Board of the NCOA with counsel from our membership units comprised of professionals and agencies working in the community with and in behalf of the elders of our society. These principles provide the foundation for an effective long-term care system.

A Yardstick for Action on Long-Term Care

1. **Shared Responsibility** Access to appropriate and affordable long-term care is a right of all Americans. While assuring such access to quality and comprehensive long-term care services is a responsibility shared by the whole society, clear roles must be accepted by government.

The federal government has a fundamental role in guaranteeing access, setting basic quality standards and, in large measure, financing that care. State governments, under federal guidelines, have responsibility to share in costs and for operational aspects of the system, including selection of providers, assurance of needed transportation services, and monitoring quality and compliance. Responsibility to assess eligibility and needs under consistent state-wide standards and to monitor the provision of services must reside with local public or private entities.

This system must encourage those who require care or who are at risk to engage in programs of self-care and in activities which can enhance recovery and wellness. Such a system must also ensure support for informal caregivers and account for their participation in care decisions.

2. **Eligibility** The design of eligibility and assessment standards and care plans should be free of limiting age and income factors. Such plans and standards must be keyed to functional impairments, including medical and psychological elements, and not to specific diseases in determining who is to be served.

3. **Financing** The financing of a comprehensive long-term care system should reflect social insurance principles, with the burden shared through federal payroll and income taxes, state and local resources, and modest copayments by users of services. Such financing could incorporate private long-term care insurance and copayments based on sliding fee-scale principles. The current system of public financing requiring the exhausting of life savings to qualify for services must be ended.

4. **Supportive Environments** All persons requiring long-term care have an inherent right to care in the least restrictive health and social service setting. That environment is preferably and practically the home and the neighborhood. Where necessary, the setting may be institutional but with a home-like atmosphere, supportive of both care recipients and caregivers.

5. **Housing** A comprehensive long-term care policy must include support to provide an accommodating housing environment at affordable prices for persons experiencing diminishing capabilities and changing needs. Such a policy would undergird the desire to remain in one's own home or in independent senior housing facilities by providing the financing and development of appropriate home and community-based service arrangements.

6. **Providers of Care** The salaried providers of care must be appropriately trained and adequately compensated in salary and benefits. Informal caregivers should also be provided with training, counseling, respite, recognition, and, where appropriate, financal incentives.

7. **Personal Autonomy** Persons who require care in their own home or in community settings, or those who are residents of institutions, have a right to determine care decisions either directly or through caregivers and guardians, including the right to refuse or terminate services. The exercise of that right requires choice from among an appropriate range of health and social services.

8. **Rehabilitation** A comprehensive long-term care program should include rehabilitation services to restore and maintain optimal physical and mental functioning.

9. **Multi-generational Needs** Impairments affect persons of all ages. The personal and public burdens of care are largely cross-generational. Long-term care public policy must be designed to incorporate these multi-generational factors.

10. **Cultural Diversity** An effective long-term care system must respect cultural and group differences among beneficiaries as well as among providers of care.

11. **Research** A comprehensive long-term care system includes adequate outlays of public and private research resources into the causes and treatment of chronic impairment. The findings of past and existing research must be more efficiently incorporated into current community and institutional practice with special care to assist informal caregivers to utilize new information. Such research must include efforts to define and advance quality standards for long-term care.

Addressing the first problem, building community services to care for those able--with help--to remain in their homes and their home communities, let me mention Wisconsin's Community Options Program--a program that works.

I suggest that the Senate Special Committee on Aging investigate the success of Wisconsin's Community Options Program. Such a study will offer evidence that providing appropriate services to individuals in their homes, and support to their care providers, is not only effective and humane, but also less costly than institutional care for the overwhelming majority of persons served. One major problem, the need for community-based service providers and care managers, is being solved in many Wisconsin communities as a revenue stream is assured through the Community Options Program. Funding follows the individual and is adequate to provide essential services.

We've found in Wisconsin that a sum equal to about 60% of the skilled-nursing facility rate is sufficient to cover a wide array of personal needs. We don't manipulate so-called core services, but, following assessment, we develop a plan that includes what one needs, not what a federal or state program permits. Our legislators and Governor, having reviewed the success of this program, are increasing appropriations for the program--evidence of strong community support.

A second Wisconsin program deserves comment. In Sun Prairie, a small community in a rural setting not far from the capitol in Madison, a true community serving elders has evolved which provides a wonderful example of what should develop across the nation. At the heart of the campus is a senior center which offers opportunities for elders to be involved in life enhancing programs, nutritious meals, health education, humanities and arts programs, and much more planned by the seniors and attractive to people who are vigorous, competent and well.

To those who have grown frail, the center provides services including adult day care, transportation, counseling, home delivered meals, therapies, exercise programs, support groups and various levels of housing to meet their diverse and changing needs for shelter with services.

Financed largely by the participants with support from local businesses, the United Way, and a mix of modest federal, state, local and county funds, the Colonial Club--as it's called--has become a "community" in which those with need for support and intervention, and their care providers, are part of the community, sharing as they are able and receiving as they have needs. A home health care agency--so badly needed by this quadrant of Dane County--has gone out of business because the federal government reneged on its commitment to reimburse such agencies in a timely and adequate manner.

The examples I've cited--Wisconsin's Community Options Program and the Sun Prairie Senior Center--underline NCOA's evidence that community-based service systems can deliver humane, effective, appropriate, comprehensive services when a solid funding foundation is provided. The NCOA has thousands of members currently delivering essential components of community long-term care on a shoestring--relying on charitable giving, volunteers, and ridiculously stingy government funds.

We can and must do a whole lot more to build supportive environments around where one lives--in the community.

With support--that flows to individuals in need rather than to categorical programs--the service infrastructure will develop at the community level, caring professionals will be attracted to provide services, and the goal of meeting the needs of people where they live, and without demeaning means tests and complicated administrative rules, will be achieved.

A second major concern the NCOA would like the Special Committee on Aging to consider pertains to the integration of shelter with services. The idea of "aging in place" is so important to so many people at-risk that a national health care policy must facilitate services that make the difference between one being forced to move and one being able to continue to live, independently with help, in familiar settings.

What is required includes training housing managers to create supportive environments for those residents increasingly in need of assistance. We need a system that will provide services to people no matter where they live. We don't need more evidence to prove that limiting services to people already in institutions--or imminently at risk of institutionalization, or recently released from institutions--makes no sense.

We need the strong support of both health care providers and housing industries to ensure that we have affordable, appropriate housing designed to enable individuals at-risk to age in place. We need to find ways to integrate services with housing to assist vulnerable residents to stay where they prefer--in their homes and apartments and not forced to relocate to nursing homes or to inappropriate shelter.

The supply of appropriate, affordable housing has shrunk over the past decade due to mis-guided efforts to limit the nation's debt at the expense of maintaining and enlarging the supply of decent housing. We know what needs to be done. We need a federal housing commitment to strengthen an effective shelter with services strategy such as the congreggate housing services program. Housing is an essential part of a health care system.

Senator Kohl, the NCOA's third issue involves the impending crisis of recruiting, training, placing and supporting care providers--including both highly-trained health and social service professionals and chronic care workers who provide so much of the care vulnerable citizens require. In addition, we need to ensure that family care providers, neighbors, volunteers--those who now and in the future will continue to provide the bulk of care at home and in the community--receive support and respite.

An effective national health care system must guarantee that the human resource needs of increasing numbers of chronically ill individuals and their families will be met. We need a national service corps, raising service to those in greatest need to high priority and respect. We need to incorporate strategies to attract individuals to the caring professions, compensate them appropriately, recognize their value to a caring nation, and undergird them with research, training and support. This matter--of who will care for those in great need--demands thoughtful planning and substantial resources.

The NCOA has reviewed national survey data and confirms the findings with the comments of our members throughout this nation--that the nation's families and those unfortunate individuals suffering from chronic or acute illness--need comprehensive health care, financed through social insurance.

Removing the cap on earnings, taxing the more than $900 billion of unearned personal income, and imposing additional taxes on alcohol and tobacco will place a solid, fair, financial base under a national health care system.

Americans find the current system confusing, under-funded, biased toward acute illness and institutionalization, and terribly expensive. The Congress should avoid tinkering with an already discombobulated non-system and offer the people of this nation a sensible, responsive, fairly financed, quality health care system. NCOA members, with forty years of experience in providing care and services in the nation's communities, will assist the Commission in designing such a system and building a constituency for its enactment.

The National Council on the Aging believes a national health care system that incorporates a responsive long-term care system is urgently needed. We must provide comprehensive services to enable persons with physical and mental impairments to remain, when possible, in their homes and, when necessary, to receive appropriate institutional care. We believe that eligibility for services must be based on impairments and not on arbitrary demarcations of age or income. Financing should be assured by social insurance.

We urge the Senate Special Committee on Aging to "dream no little dreams" when it concerns the urgent and growing need for an adequate response to our overwhelming need for comprehensive, quality, person-centered, health care. The health care system we envision includes disease prevention and health promotion, supports informal caregivers, and incorporates significant research and training commitments. Financing this program requires universal social insurance; fiddling with private long term care insurance schemes would waste precious time and limited resources.

5939L

Item 2

Dunn County Office on Aging
808 Main Street
Menomonie, Wisconsin 54751
Phone: (715) ~~235-0603~~ 232-4006

December 1, 1989

Honorable Senator Herbert Kohl
708 Hart
Senate Office Building
Washington, D.C. 20510

Dear Honorable Senator Kohl,

The following are a number of cases where the elderly have been subjected to either fear or the very nice guy syndrome by unethical health insurance agents who are determined to sell their policies even though the additional policy or a policy change is not necessary. In one case the same agent in a year called on this person to convince her that the previous policy is not as good as the policy he now has for sale. Please note the agent receives up to 70% of the first year's premium and one can see why the agent wants to sell a replacement policy.

In another case, a lady I like to think of as a pillar of the community, was sold five policies. She needed one policy to meet her needs. Or, the lady who had an agent in her home for six hours (wouldn't leave) trying to sell her a replacement policy.

Names are not listed because of confidentiality. Because of the ages of the people in the cases listed and their frailty prevents them from being at the senate hearing today.

The cases are:

Case #1: A widow of 92 years old, just above the medical assistance income level, thought she was buying coverage for nursing homes. After paying for the policy she was given the booklet explaining coverage. The policy was a Medicare Supplement.

Case #2: An 83 year old widow on PartnerCare has had a 20% Medicare Supplement for many years costing $584.00 per year. An agent from 200 miles away convinces her to buy a policy for $900.00 that covers usual and customary charges which is not necessary in her situation.

Case #3: A woman told the agent of preexisting condition. However the agent did not accurately complete the form. Later when a claim was filed there was no coverage because of these preexisting conditions. The company canceled the policy.

Case #4: A 79 year old widow was afraid to drop insurance because of serious heart problems. Three different agents are involved switching her to four different individual policies during a four year period. All during this time she continues to keep a Medicare Supplement through AARP, two cancer policies with different companies and an accident policy. She spends over $1,700.00 per year for health insurance policies (not including Medicare) but has a medical assistance medically needy spend down of $735.00 a year.

Case #5: A couple is dropped from their group health insurance when she turns 65. She is not insurable under any Medigap individual policy without a waiting period because she is in the hospital and seriously ill.

Case #6: An 83 year old single woman who has shown signs of serious confusion for several years has five Medicare Supplements and a nursing home policy. The last agent to sell a policy helps to cancel all previous policies. This woman has Social Security Income of only $318.00 per month. A relative is power of attorney now that she is in a nursing home after a fall.

Case #7: A woman is told by an agent that he can sell her a policy that is a "twin" to her present Medicare Supplement but at half the price! She buys the policy but finds out later after talking with the County Benefit Specialist that it isn't even a Medicare Supplement. The policy was a surgical/medical policy.

Case #8: A 76 year old widow with no family support had shown serious signs of dementia. Her bank notified the County Benefit Specialist because all her checks were being written to insurance companies. In the previous eight years she had been sold nine Medicare Supplements (four of the policies were still in force), one daily indemnity, five life insurance policies (three in force but she didn't want life insurance) and two cancer policies. Several agents switched policies regularly or sold her one of each kind of policy. This woman was unable to say no to agents. Three years later she still has no protection from unethical agents since she is not willing to ask for help. She has no family willing to intervene and the court system is saying she is still competent enough to make her own decisions.

Case #9: Agent sells a couple a Medicare Supplement costing over $2,800.00 for both. They already have two other Medicare Supplements and a cancer policy. They do not understand Medicare or supplemental insurance.

Case #10: Three widows in their 80's have been on the high option group plan with the federal government at $187.00 per month. The low option for $38.00 per month has never been explained to them and they have been afraid to change.

These are just a few examples of cases showing the confusion and problems older people are having with Medicare Supplements. There are many others who never come to the attention of the County Benefit Specialist or volunteers assisting as Medicare Helpers. What is happening to them?

The Wisconsin proposed rule change would be a move in the right direction but more must be done to protect older people and help them understand the complicated health care system.

Sincerely,

Margaret Hagaman

Margaret Hagaman
Dunn County Benefit Specialist

MH/sb

David L. Becker Item 3

Testimony to:

SPECIAL COMMITTEE ON AGING

Field Hearing Madison, Wisconsin December 11, 1989

The role of insurance agents in the sale of Medicare supplement policies cannot be addressed without considering the overall marketing practices of the companies and the confusion of the public over the issue of health care for senior citizens. The Federal Medicare program and its ever-changing position in delivering benefits requires private insurance companies to adjust the benefits and premiums annually. As the premiums and benefits offered by companies are altered, agents who represent these companies have opportunities to review policies with senior citizens every year. Since these activities are closely interrrelated, I will atempt to describe the situation as seen from the sales arena, try to describe the scenario as it exists now, and propose a possible solution to eliminate injustices to our senior citizens.

For the purpose of this testimony, I will assume that all companies issue policies that are adequate, fairly priced, and claims are paid with fairness and dispatch. My testimony will deal with the statement that it is the delivery system which is suspect, and which should change.

The career insurance agent who is captive, or represents one company, solicits business by writing the first policy for a citizen at age 65, or compares coverages and rates with existing policies already in force on those policyholders who are over 65. Although there are some people over 65 who do not have a Medicare supplement policy, a large percentage of them do, and an agent can gain an interview rather easily by offering a free "review of your Medicare supplement policy" or, offer to "come out and explain your Medicare to you". Although there are are laws dealing with ethical practices, the "any way to get in the door" approach seems to prevail in the marketplace. The practice of the single company agent is limited to represent or misrepresent the policy of his company as being better than another in-force or proposed policy. The one-company agent is not the usual culprit in the exploitation of senior citizens in the marketing of Medicare supplement insurance.

The independent agent, on the other hand, has great opportunity to abuse the system, and to exploit both the senior citizen and the company. The independent agent is an agent who is licensed to represent several companies who market the same or similar products. Many companies that do business in our state are those who market their products through independent agents. Since each company knows the independent agent is free to place the business with the company of his choice, each company will try to become the preferred company of that agent by offering higher first year commissions than the companies whose agency force is "captive". Currently, the commissions on policies marketed by independent agents may range from as low as 15% to as high as 75% of the first year premium. The independent agent will obtain contracts with the companies paying the higher commisssions, thus making his business more profitable for each sale he makes.

The scenario that has caused concern by advocacy groups, commissioners' offices, outreach workers, and others, is this:

1. The agent makes a legitimate approach to the prospect to review the Medicare supplement insurance. If the prospect has a Medicare supplement policy in force, the agent is making the call with the sole intent to replace the policy. If the policy was originally written by the same agent and the insured pays the renewal premium, the agent will receive a renewal commission of 10-12% each time the premium is paid. However, if it is replaced with a policy of another company, the agent receives the new business commission, up to 75% of the annual premium.

2. Most, but not all policies contain a pre-existing condition clause, which excludes coverage for any condition or treatment which occurred during a specific time period prior to the effective date of the policy. This period of time may be 60, 90, or even 180 days. If the new policy in a replacement situation has such a clause, the agent is jeopardizing coverage for the insured, since any condition not covered by the new policy would be covered by the existing one. However, if a strong enough case is made by the agent, the policy is still replaced, the agent is paid for his action, and the insured is exposed to severe loss for the period of time covered by the pre-existing clause.

   If the agent is aware of the time factor, he will call on the insured 60, 90, or even the full 180 days prior to the renewal date of the existing policy. The new policy will be dated as of the date of the call, and for the time period stated above, the insured will have coverage from two policies, for which premiums have been paid, and first year commissions have been paid to the agent. After the time period has expired, the new policy will cover those pre-existing conditions, and the old policy is allowed to lapse. The result of this action is this: The agent has been paid 2 new business commission checks within 6-9 months, the insured has paid 2 annual premiums within the same time period, and has had double coverage for an extended period.

3. The agent has just begun with this insured, however. With each change in the Medicare law, or increase in the deductible, the agent can call on the insured again and again, each time telling the insured that there's a very good reason for replacing the policy he has. The waiting periods are carefully watched, and the insured could pay 3 and even 4 annual premiums for Medicare supplement insurance over a 2 year period. When there is a husband and wife situation, this can be accomplished twice in one household. With an average premium of $1200, and a commission of 60%, the agent could conceivably pocket $4,680 within 1 year and 9 months, if the 90 day pre-existing clause is in evidence. If one policy were sold and renewed for one additional year, the commission to the agent would be $1,680, assuming a 10% renewal commission.

It must be noted that the above practice may be the exception, and not the rule. However, the practice is real, and since I have begun talking with outreach workers and other advocates for the elderly, I have learned that the situation we witnessed in our town was one of many in our county and area.

This practice of replacement also exploits the companies. While I don't have hard figures, I am aware that the sales organizations for most companies who work through independent agents market their products through General Agencies, who receive an override, or a commission in addition to that paid by the agent. Thus, we can safely add 20% to perhaps 25-30% commission payment on the first year premium. In essence, then, the cost to the company for issuing a new policy could be in excess of 100% of the first year premium in commission payments alone. And there are other underwriting costs, which are not considered here. I have written to 9 companies asking them to tell me the cost of issuing a Medicare supplement policy, and as of this date, do not have a response. My assumption is that it will cost the company approximately 125% of the first year's premium to issue a new policy. This means that in order for the company to realize a profit on a policy, it must be renewed at least once, with no claims against it.

The scenario and it's effect on the companies is this:

1. The agent writes policy #1 from Company A. Company A absorbs all issue costs. Agent is paid first year commission.

2. One year (or less) later, the agent calls on the insured to "renew" the policy, and replaces the policy from Company A with policy from Company B. Company A's policy lapses, resulting in a loss to Company A. Company B absorbs issue costs. Agent is paid another first year commission.

3. One year (or less) later, the agent calls on the insured to "renew" the policy again. Perhaps due to changes in Medicare coverages, agent can convince insured that Company A's policy, which was not good enough "last year" now is better than Company B's policy. Another replacement. Another lapse. Company B loses, Company A assumes a second issue cost on the same insured, agent receives the third first year commission on this person. This practice could continue for years. I'm familiar with two such replacements on a 96 year-old lady!

4. The companies would experience an "adverse selection" situation, in that the agent who replaces insurance will approach only those insureds who are healthy and can qualify for a new policy, and will avoid those who are poor risks. Those who have had claims, or those who have had a deterioration of health would be unable to secure a policy from another company because of their condition or claims history. They would be likely to generate additional claims in the future. Those who qualify would leave the company, with the higher risk policyholders remaining. Good leaves / bad stays.

One would think that the companies would "get wise" to this activity. I'm sure some of them are. However, because of our experience with an agent formerly with our agency and our conversations with one company and one general agency, we found deaf ears because the agent was demonstrating "sales activity". I have also asked the companies I contacted if they kept records on retention, and if they could tell which agents seem to have poor persistency. I asked them if they felt it was more profitable to renew a policy than to reissue it every other year. As I understand it, in our state, when a Medicare policy or other health insurance policy is replaced, the insured signs a replacement form in duplicate. One copy is left with the insured, and one copy is sent to the replacing company. The company whose policy is in jeopardy is not contacted. Later, when the policy lapses, the agent may or may not receive notification from the company. Usually, however, by the time this occurs, the replacement policy has been in force for several month, due to the overlap, and the pre-existing condition clause. When the replacing agent and the agent whose policy was replaced are the same agent, it's assured that nothing is done to conserve the original policy. The entire system of delivery seems to lend itself to continuous replacement to the advantage of the agent and the disadvantage of the insured(s) and the company.

In light of the above information, I am making a proposal that by regulation, legislation, or by company policy the following action be taken: (some states currently have regulations in force that are similar to this)

1. Pay the full **new business** commission to an agent who:

   A. Writes the **first** Medicare supplement or nursing home policy on a senior citizen, or:

   B. Writes a Medicare supplement policy or nursing home policy for a person who has had **no coverage** of **this type** in force for **6 months.** (someone who has had a policy, but it had lapsed, and the person has been without insurance for 6 months)

2. Pay the company's current **renewal** commission rate on **first year and subsequent year premiums** if:

   A. The policy written replaces an existing Medicare supplement or nursing home policy, or:

   B. There has been a policy of this type in force during the **six months immediately prior** to the effective date of the new policy.

3. Require a 3-part replacement form to be completed and signed by the insured and the agent, with one copy to the insured, one copy to the replacing company, and one copy to the company whose policy is being replaced. (Life insurance regulations currently require this practice, and require the address of the agent to be included)

It is my belief that implementation of the above recommendations can accomplish the following:

1. Eliminate the profit incentive for the agent who makes it standard practice to continually prey on the same people who have once trusted him/her, and to deceive and expolit them.

   The agent who is serious about marketing products in the senior market can still make a good living by prospecting in the market of those seniors who are reaching Medicare age. The "chronic replacers" will find their source of income such that they would not continue the practice.

2. Restore confidence in the insurance industry, by replacing the pure profit motive with a service-oriented attitude. A "policy review" will now be a policy "re-view", and not an excuse to replace.

   The agent who replaces a policy still is paid for his/her efforts, and the replacement transaction would likely be one of more direct benefit to the insured than to the agent. Perhaps a company has a lower premium, or a better benefit, and the agent can receive a fee for being of "good service" to the client.

3. Enable the company to monitor the activities of its agents more closely. An agent replacing a policy will be disclosing to each company what his/her intentions are. If the agent replaces the business he/she wrote originally, the company whose policy is replaced can respond and, if this activity reaches an unacceptable level, the company may cancel the contract with the agent. If the agent has no company contract, he's not in business with that company from that point on. We have seen behavior to circumvent it, but with the profit gone, hopefully, so is the bad agent.

4. Increase the profitability of the companies.

   1. Ideally, only one incentive-based high issue cost would be incurred by any company on each person who purchases a Medicare supplement or nursing home policy. If a company issues a policy, and subsequently loses it, and reissues it again for whatever reason, the liability to the agent would only equal the same commission as though it had been renewed. The home office would incur its clerical and other costs of issuing a new policy, but if it pays 12% instead of 65% of the premium as commission, the company can retain 50% or more of the annual premium to offset those costs.

   2. The policies written with a specific company would stay with that company. With retention levels increasing, and with both the healthy and the unhealthy persons remaining with the company to "balance the book" as it were, the loss experience would improve, and profits for the company would rise. Adverse selection would not be a problem for the company.

3. The companies would be in a better position to monitor the practices of the agents who represent them, since the agent who replaces a policy discloses his/her actions to both the new and the former company. Since Medicare supplement policies in our state have been standardized, each can be modified to match those sold by other companies. Companies can capture their market share by being competitive with rates and service. They wouldn't be "shooting themselves in the foot" by contracting agents who abuse the independent status by annually replacing their book of business at the expense of the company.

It is my hope this information has some value to your committee. The senior citizen population in our country is growing rapidly, and with that growth come problems and opportunities.

To this point, at least in the industry I represent, the problems have been laid at the feet of the senior citizen, and the opportunities have been handed to the independent insurance agents, who convert them to profit with the resulting:

1. Financial loss to the companies

2. Further erosion of confidence in our industry which already suffers from the stigma of greed on the part of the agents and companies.

3. Exploitation of our senior citizen population, who are confused about the ever-changing Medicare situation, and who write checks to agents under unnecessary pressure.

There is a better way. I believe there is no alternative to insurance that can provide what it delivers. A partnership between the governmental bodies and private industry, better supervision of agents, and sound product delivery practices can accomplish the goal of helping our senior citizens enjoy their golden years more worry free. Theirs should be the opportunity, not the problem.

Item 4

State of Wisconsin \ OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Robert D. Haase
Commissioner

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Testimony by
ROBERT D. HAASE
Commissioner of Insurance
Office of the Commissioner of Insurance (OCI)
Madison WI 53707

December 11, 1989

Senator Kohl, ladies and gentlemen. Thank you for inviting me to comment on Medicare supplement policies from the regulator's perspective. You asked me to limit my remarks to four areas:

1. Describe the current process of regulation.

2. Give the history of rates and benefits for the past five years.

3. Indicate what impact repeal of the Catastrophic Health Care Act has had on the content and cost of Medicare supplement policies.

4. Discuss the role of hospital indemnity policies and whether they should be prohibited.

In order to do that, let me first give you a thumbnail sketch of the evolution of Medicare supplement policies.

Prior to Medicare, health insurance for the elderly was virtually non-existent. After the creation of Medicare, insurers realized that a market existed where they could define the limits of their potential risk. Insurers began marketing policies to fill the gaps in Medicare in the early 1970s. Many abuses occurred. Persons purchased policies that offered little or no protection against the costs not covered by Medicare.

Both the National Association of Insurance Commissioners (NAIC) and the Congress began studying the problem. As a result, the NAIC adopted its first model act to regulate Medicare supplement policies in 1980. Congress adopted the Baucus amendment the same year. This law required minimum standards for policies designed to supplement Medicare and directed the states to develop minimum standards for the policies.

Wisconsin was a leader in attempting to resolve the problem and to develop standards for Medicare supplement policies. Former commissioners Wilde and Mitchell worked with congressional committees and chaired the NAIC task force that developed the model regulation for minimum policy requirements.

Wisconsin first promulgated rules to regulate Medicare supplement policies in 1977, before either the NAIC or the Congress took action. This regulation, Wisconsin Administrative Code s. Ins 3.39, was revised in 1980 to bring it into accord with the Baucus amendment. We have revised the rule several times since then to bring it into accord with federal law and to alleviate abuses that occurred. Assuming that President Bush will not veto the bill, just last week we issued an emergency rule to bring the regulation into compliance with federal law following repeal of the Catastrophic Health Care Act.

Ins 3.39 specifies the benefits a policy must provide to be called a Medicare supplement policy, details provisions that insurers must include on the face of the policy, spells out type size and color, requires minimum loss ratios, and requires that the "Health Insurance Advice for Senior Citizens" booklet be given at the time of solicitation. In addition, Wisconsin has stringent rules governing the marketing and advertising of Medicare supplement policies.

In addition to the state laws and regulations that govern all health insurance policies, persons who purchase Medicare supplement policies are guaranteed the right to return the policy within 30 days of receipt and receive a full premium refund. Also, insurers may not exclude pre-existing conditions for more than 6 months.

When our department first promulgated Ins 3.39, insurers were permitted to offer four categories of Medicare supplement policies. A Medicare supplement policy 1 offered the most comprehensive benefits, and a Medicare supplement policy 4 offered the least. In 1980, the Medicare supplement 4 policies were no longer allowed.

When the Catastrophic Health Care Act passed, we saw it as an opportunity to revise our regulations and, hopefully, make comparison shopping easier for the consumer. We required all insurers offering a Medicare supplement policy to develop a basic benefits package that complied with federal requirements. The company could then offer only specific riders offering benefits not covered by Medicare.

Insurers can only offer riders for: the Part A deductible, Part B deductible, usual and customary charges for outpatient prescription drugs, additional home health benefits, foreign travel, and Part B usual and customary charges over and above what Medicare allows.

Following the repeal of the Catastrophic Act, we retained the basic policy with the six specific permissible riders. However, we now require insurers to cover the hospital copayments beyond the 61st day under the base policy and allow them to include a $100 deductible to the outpatient prescription drug rider.

The late action by Congress has thrown the Medicare supplement insurance market into a quandry. Companies have not had time to react, particularly those that market in several states. We expect, however, to have 5-10 policies submitted and approved by the end of the month.

In most cases, policies that are in effect today will continue to provide coverage as long as the premium is paid. However, even there, we don't know what the premium will be as insurers have not had the opportunity to develop the rates. The Health Care Financing Administration is part of the problem as it is unclear what the Part A hospital and skilled nursing copayments will be for 1990.

What impact will repeal of the Catastrophic Act have on rates? We can't be certain until companies actually begin filing those rates with us. However, according to the results of a survey released by the House Select Committee on Aging, Wisconsin rates are only anticipated to increase 11% as opposed to 133% in Arizona, 120% in Missouri and 75% in several states. I think that Wisconsin's lower rate of increase is attributable to a number of things.

First, we have imposed minimum loss ratios for several years. Some other states are only now taking this approach. Second, we have a very competitive health insurance market. This tends to keep increases at a minimum. Third, although the overall costs of health care are increasing, the rate in Wisconsin has not increased at the same rate as some of the states that report astronomical rate increases for the Medicare population.

When talking about rates, it is important to remember, Senator, that health insurance premiums reflect what is happening in the marketplace. Health care costs continue to increase at double the rate of inflation. People live longer and, consequently, require more care. Technology has improved but is costly. People demand more health care. Because Medicare supplement policies actually supplement Medicare, their rates also reflect decisions that the Health Care Financing Administration makes about what is allowable under Medicare.

I have provided you some historical rate data (Exhibit 1). Although Wisconsin does not pre-approve rates, companies are required to file their rates with us. Because of the minimum loss ratio requirement, we closely review the rate filings to assure that the companies are complying.

Senator Kohl, you asked me to comment on hospital indemnity policies and whether they should be allowed. Personally, I believe that consumers should have the right to purchase a hospital indemnity policy if they so choose as long as they receive adequate disclosure about the limited benefits of the policy. We have attempted to do that through regulation and consumer information. Any hospital indemnity policy marketed in the state must contain a disclosure on the face of the policy indicating that it is a limited benefit policy (Exhibit 2). In addition, the "Health Insurance Advice for Senior Citizens" booklet (Exhibit 3) that must be given to all seniors at the time of solicitation contains an explanation of limited policies such as hospital indemnity policies.

Thank you for the opportunity to appear before you.

State of Wisconsin \ OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

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EXHIBIT 1

Attached are 1988 Wisconsin Medicare Supplement Experience Data, 1987 Wisconsin Medicare Supplement Experience Data, and 1988 Medicare Supplement Market Shares.

The experience data for 1987 and 1988 includes data for business written only in those respective years. Loss ratios are determined by dividing the incurred claims by the earned premium.

Incurred claims are the claims paid during the respective year plus the current year's unpaid claims and reserves less unpaid claims incurred for prior years. Reserves are an actuarially determined amount.

Open block means that new policies were issued during the respective year, either 1987 or 1988. Closed block means policies are still in force and are still being renewed by existing policyholders but where no new policies were issued during the respective year.

Loss ratios are developed over a number of years for a particular block of business. A low loss ratio may indicate that the company has only recently started marketing the block of business or has a small volume of business in Wisconsin. The loss ratio increases as the block of business ages.

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Attachment

1988 WISCONSIN MEDICARE SUPPLEMENT EXPERIENCE DATA

	COMPANY	1988 EARNED PREMIUMS OPEN BLOCKS	1988 EARNED PREMIUMS CLOSED BLOCKS	1988 INCURRED CLAIMS OPEN	1988 INCURRED CLAIMS CLOSED	ACTIVE LIFE RESERVE INCREASE OPEN	ACTIVE LIFE RESERVE INCREASE CLOSED	LOSS RATIOS OPEN	LOSS RATIOS CLOSED	LOSS RATIOS TOTAL
1	AAL	1,773,323		1,143,554		238,192		77.92%	ERR	77.92%
2	AM FAM LIFE ASSU	778,387	549,551	108,922	256,205	0	0	13.99%	46.64%	27.50%
3	AMERICAN FAMILY	890,872		413,941		0		46.46%	ERR	46.46%
4	AMERICAN INCOME							ERR	ERR	ERR
5	AMER. MOTORISTS							ERR	ERR	ERR
6	AMER. REPUBLIC	745,767	77,492	309,167	17,704	0	(5,680)	41.46%	15.52%	39.01%
7	BANKERS L&C	14,829,586	1,592,847	8,348,143	759,577	115,875	19,886	61.11%	57.65%	60.82%
8	BC/BS OF WIS.	27,730,000	15,242,000	18,325,000	9,020,000	0	0	66.08%	59.18%	63.63%
9	BENEFIT TRUST	277,840		155,592		6,150		58.21%	ERR	58.21%
10	CENTRAL STATES	4,154,142		1,712,711		119,861		44.11%	ERR	44.11%
11	COLONIAL PENN	1,779,580		960,980		0		54.00%	ERR	54.00%
12	COMBINED INS	15,117		4,930		2,852		51.48%	ERR	51.48%
13	COMPCARE		443,416		336,904		0	ERR	75.98%	75.98%
14	CNA	2,495,220	23,323	1,383,614	16,601	85,050	(5,158)	58.86%	49.06%	58.77%
15	CONT GENERAL	136,345		97,093		2,391		72.96%	ERR	72.96%
16	DEAN HEALTH PLAN	5,547,749		4,508,027		0		81.26%	ERR	81.26%
17	FAMILY HEALTH PL	11,992,426		6,421,930		0		53.55%	ERR	53.55%
18	FEDERAL HOME	544,025	252,190	325,994	133,436	8,182	4,733	61.43%	54.79%	59.32%
19	FEDERAL LIFE	455,529		222,299		0		48.80%	ERR	48.80%
20	GLOBE L&A		37,384		24,473		(2,129)	ERR	59.77%	59.77%
21	GRT LA CROSSE	666,625		480,383		0		72.06%	ERR	72.06%
22	GP HEALTH EAUCLAIRE		364,560		335,174			ERR	91.94%	91.94%
23	GHC SOUTH CENTRA	104,186		55,793		0		53.55%	ERR	53.55%
24	GUARANTEE TRUST	1,369,750	181,961	669,127	162,414	82,752	(11,488)	54.89%	82.94%	58.18%
25	HMO MIDWEST	15,587		3,742		0		24.01%	ERR	24.01%
26	HMO OF WISCONSIN	682,182		504,841				74.02%	ERR	74.02%
27	LUMBERMEN'S							ERR	ERR	ERR
28	LUTH. BROTH.	125,351	130,991	50,400	65,160	16,127	13,699	53.07%	60.20%	56.72%
29	MASS INDEMNITY							ERR	ERR	ERR
30	MED ASS HMO	758,219		669,269				88.27%	ERR	88.27%
31	MEDICO LIFE	30,595	52,417	28,518	26,792	0	0	93.21%	51.11%	66.63%
32	MIDAMERICA LIFE	588,723		388,822		11,120		67.93%	ERR	67.93%
33	MIDELFORT CLINIC	1,819,304		1,198,983		0		65.90%	ERR	65.90%
34	MUTUAL OF OMAHA	3,931,933	1,853,106	2,430,350	1,452,557	0	0	61.81%	78.38%	67.12%
35	MUT. PROT. LIFE	219,799	67,513	243,547	29,408	0	0	110.80%	43.56%	95.00%
36	NATL CASUALTY	2,311	13,016	3,063	17,035	37	208	134.14%	132.48%	132.73%
37	NATIONAL HOME		109,334		70,623		(2,681)	ERR	62.14%	62.14%
38	NATIONAL STATES	2,398,445	581,259	912,292	490,760	21,093	7,590	38.92%	85.74%	48.05%
39	NATL TRAV LIFE	12,054	7,725	12,970	3,965		(8,992)	107.60%	51.33%	85.62%
40	NEW YORK LIFE		198,409		93,818			ERR	42.75%	42.75%
41	NORTH AMERICAN		55,362		43,015			ERR	77.70%	77.70%
42	NORTH CENTRAL	345,868		249,024				72.00%	ERR	72.00%
43	PENN LIFE							ERR	ERR	ERR
44	PEKIN LIFE	121,973	1,479	50,670	(1,539)	14,141	(632)	53.14%	-146.79%	50.74%
45	PIONEER LIFE	2,742,654		1,420,849				51.81%	ERR	51.81%
46	PHYS. MUT. LIFE	10,307,859	3,734,455	7,440,426	2,957,035	533,046	164,364	77.35%	83.58%	79.01%
47	PHYSICIANS PLUS	713,509		424,076				59.44%	ERR	59.44%
48	PRINCIPAL MUT	6,299,034		4,557,240				72.35%	ERR	72.35%
49	RURAL		1,384,001		1,043,550		0	ERR	75.40%	75.40%
50	SECURITY HLT PLA	11,408,296		9,396,078		0		82.36%	ERR	82.36%
51	STATE FARM MUT	2,461,626		1,508,383		0		61.28%	ERR	61.28%
52	TIME		470,952		160,310		20,820	ERR	38.46%	38.46%
53	UNION LABOR LIFE	274,637		191,712		6,964		72.34%	ERR	72.34%
54	UNITED AMERICAN	10,385,216	756	6,208,338	52	588,282	(20)	65.45%	4.23%	65.44%
55	WIS HEALTH ORG	69,095		26,001		0		37.63%	ERR	37.63%
56	WPS	5,848,383	20,787,483	3,798,350	16,656,732	0	0	64.95%	80.15%	76.80%
	TOTAL	137,849,442	47,971,962	87,965,248	34,171,757	1,850,113	194,520	65.15%	71.64%	66.83%

1996 WISCONSIN MEDIGAP SUPPLEMENTAL EXPERIENCE DATA

COMPANY	1996 EARNED PREMIUMS OPEN BLOCKS	1996 EARNED PREMIUMS CLOSED BLOCKS	1996 INCURRED CLAIMS OPEN	1996 INCURRED CLAIMS CLOSED	ACTIVE LIFE RESERVE INCREASE OPEN	ACTIVE LIFE RESERVE INCREASE CLOSED	LOSS RATIOS OPEN	LOSS RATIOS CLOSED	LOSS RATIOS TOTAL
1 AAL	1,623,775		900,701		540,148		76.42%		76.42%
2 AM FAM LIFE ASSU	367,968		96,833		0		26.32%		26.32%
3 AMERICAN FAMILY	608,542		303,993		0		49.95%		49.95%
4 AMERICAN INCOME		8,641		5,379		0		61.96%	61.96%
5 AMER. MOTORISTS		250		512		(350)		21.60%	21.60%
6 AMER. REPUBLIC	432,778	93,592	153,084	49,867	0	3,127	11.52%	56.62%	29.19%
7 BANKERS LIFE	13,340,890	1,758,535	11,521,394	908,525	70,244	(164,402)	65.94%	42.51%	61.45%
8 BC/BS OF WIS.	50,735,000	14,054,000	21,657,000	7,831,000	0	0	70.46%	41.5%	59.35%
9 BENEFIT TRUST	371,305		219,546		7,465		61.14%		61.14%
10 CENTRAL STATES	1,555,800		941,256		59,930		41.21%		41.21%
11 COMPCARE	462,959		253,382		0		54.72%		54.72%
12 CNA		1,290,377		1,500,400		60,629		68.16%	68.16%
13 CONT GENERAL	83,624		24,013		0		28.72%		28.72%
14 DEAN HEALTH PLAN	3,683,629		3,868,235		0		105.01%		105.01%
15 FAMILY HEALTH PL	6,356,737		4,725,559		0		68.83%		68.83%
16 FEDERAL HOME	854,876	196,169	491,717	54,147	23,531	(12,218)	55.5%	35.33%	52.70%
17 FEDERAL LIFE	255,093		144,966		0		56.44%		56.44%
18 GLOBE USA	extension to 6/30						ERR	ERR	ERR
19 GRT LA ORDSJE	310,935		141,857		0		57.33%		57.33%
20 GP HEALTH EAUCLA	81,348		70,332		0		86.46%		86.46%
21 GHC SOUTH CENTRA	99,576		42,493				42.67%		42.67%
22 GUARANTEE TRUST	991,655	673,340	885,811	185,419	30,029	13,470	52.08%	29.54%	42.93%
23 HMO OF WISCONSIN	472,850		400,859		0		84.78%		84.78%
24 LUMBERMENS		4,485		(22,207)		(1,200)		-521.90%	-521.90%
25 LUTH. BROTH.	47,312	143,796	12,612	71,024	7,375	10,816	42.25%	57.07%	53.39%
26 MASS INDEMNITY		2,414		137		0		5.68%	5.68%
27 MED ASS HMO	636,529		530,867		0		83.35%		83.35%
28 MEDICO LIFE	24,764	103,745	21,635	48,102	0	0	87.36%	46.36%	54.18%
29 MIDAMERICA LIFE	509,974		215,726		47,388		51.59%		51.59%
30 MIDELFORT CLINIC	959,098		926,270		0		96.58%		96.58%
31 MUTUAL OF OMAHA	3,239,608	2,365,515	1,633,511	1,938,433	0	0	50.42%	81.92%	65.73%
32 MUT. PROT. LIFE	219,785	115,785	217,324	41,744	0	0	98.84%	37.70%	77.77%
33 NATL CASUALTY	1,465	16,647	185	9,981	(14)	533	11.54%	63.16%	58.96%
34 NATIONAL HOME		132,068		87,693		(3,401)		63.82%	63.82%
35 NATIONAL STATES	2,007,151	838,734	432,443	648,316	0	4,301	21.55%	77.81%	38.13%
36 NATL TRAV LIFE	9,205	10,305	4,360	(3,186)	0	0	47.37%	-30.92%	6.02%
37 NEW YORK LIFE	236,194	4,391	119,752	(470)	3,172	923	52.04%	10.52%	51.28%
38 NORTH CENTRAL	197,688		142,235		0		71.95%		71.95%
39 PENN LIFE		7,901		4,909		0		62.13%	62.13%
40 PEKIN LIFE	99,397	1,902	32,283	9,694	5,235	32	37.75%	511.36%	46.64%
41 PIONEER LIFE	576,745		308,443		0		53.48%		53.48%
42 PHYS. MUT. LIFE	7,695,654	4,057,252	5,286,227	3,095,575	494,979	313,544	75.12%	84.02%	78.19%
43 PHYSICIANS PLUS	462,249		406,779		0		88.00%		88.00%
44 PRINCIPAL MUT	5,648,592		4,202,200		0		74.39%		74.39%
45 RURAL	1,426,392		1099,135		0		65.04%		65.04%
46 SECURITY NAT PLA	10,432,305		7,652,249		0		75.16%		75.16%
47 STATE FARM MUT	1,344,040		775,402		0		57.54%		57.54%
48 TIME	115,251	330,630	24,354	79,445	0	25,954	21.13%	31.27%	28.65%
49 UNION LABOR LIFE	298,150		228,526		4,487		78.15%		78.15%
50 UNITED AMERICAN	extension to 6/30						ERR	ERR	ERR
51 WIS HEALTH ORG	30,203		34,075		0		112.82%		112.82%
52 WPS	4,757,051	19,752,152	3,041,335	15,010,082	0	0	63.93%	75.97%	73.63%
TOTAL	103,664,553	51,899,986	69,613,536	31,607,219	1,293,769	249,758	68.40%	61.38%	66.06%

1987 WISCONSIN MEDICARE SUPPLEMENT EXPERIENCE DATA

	COMPANY	EARNED PREMIUM	INCURRED LOSSES	LOSS RATI TOTAL
1	UNITED AMERICAN	0	0	ERR
2	GLOBE L&A	0	0	ERR
3	WIS HEALTH ORG	30,205	34,075	112.82%
4	DEAN HEALTH PLAN	3,683,629	3,868,235	105.01%
5	MIDELFORT CLINIC	959,098	926,278	96.58%
6	PHYSICIANS PLUS	462,249	406,779	88.00%
7	GP HEALTH EAUCLA	81,346	70,332	86.46%
8	HMO OF WISCONSIN	472,850	400,859	84.78%
9	MED ASS HMO	636,529	530,589	83.35%
10	PHYS. MUT. LIFE	11,752,906	9,190,125	78.19%
11	UNION LABOR LIFE	298,150	233,813	78.43%
12	MUT. PROT. LIFE	335,560	260,968	77.77%
13	AAL	1,623,773	1,240,849	76.42%
14	PRINCIPAL MUT	5,648,592	4,202,200	74.39%
15	WPS	24,516,207	18,051,417	73.63%
16	SECURITY HLT PLA	10,432,305	7,632,249	73.16%
17	NORTH CENTRAL	197,688	142,235	71.95%
18	FAMILY HEALTH PL	6,356,737	4,375,559	68.83%
19	CNA	2,290,377	1,561,029	68.16%
20	NATIONAL HOME	132,060	84,292	63.82%
21	MUTUAL OF OMAHA	5,605,123	3,571,944	63.73%
22	RURAL	1,426,392	899,185	63.04%
23	PENN LIFE	7,901	4,909	62.13%
24	AMERICAN INCOME	8,681	5,379	61.96%
25	BANKERS L&C	15,199,445	9,337,759	61.43%
26	BENEFIT TRUST	371,305	227,011	61.14%
27	BC/BS OF WIS.	49,789,000	29,539,000	59.33%
28	NATL CASUALTY	18,112	10,683	58.98%
29	STATE FARM MUT	1,344,040	773,402	57.54%
30	GRT LA CROSSE	310,935	178,257	57.33%
31	FEDERAL LIFE	255,098	143,966	56.44%
32	COMPCARE	462,959	253,322	54.72%
33	MEDICO LIFE	128,709	69,737	54.18%
34	PIONEER LIFE	576,745	308,445	53.48%
35	LUTH. BROTH.	190,708	101,827	53.39%
36	FEDERAL HOME	981,045	516,977	52.70%
37	MIDAMERICA LIFE	509,974	263,114	51.59%
38	NEW YORK LIFE	240,585	123,377	51.28%
39	AMERICAN FAMILY	608,542	303,968	49.95%
40	PEKIN LIFE	101,299	47,244	46.64%
41	GUARANTEE TRUST	1,664,995	714,729	42.93%
42	GHC SOUTH CENTRA	99,576	42,495	42.67%
43	CENTRAL STATES	1,555,806	641,136	41.21%
44	AMER. REPUBLIC	526,370	206,075	39.15%
45	NATIONAL STATES	2,845,865	1,085,060	38.13%
46	CONT GENERAL	83,624	24,013	28.72%
47	TIME	445,181	127,755	28.69%
48	AM FAM LIFE ASSU	367,968	96,833	26.32%
49	AMER. MOTORISTS	750	162	21.60%
50	NATL TRAV LIFE	19,510	1,174	6.02%
51	MASS INDEMNITY	2,414	137	5.68%
52	LUMBERMEN'S	4,435	(23,407)	-521.90%
	TOTAL	155,564,539	102,764,282	66.06%

MEDICARE SUPPLEMENT MARKET SHARES

COMPANY	1988 EARNED PREMIUM	1988 POSITION	1988 MARKET SHARE	1987 EARNED PREMIUM	1987 POSITION	1987 MARKET SHARE
BC/BS OF WIS.	$42,972,000	1	23.13%	$49,789,000	1	30.08%
WPS	26,635,866	2	14.33%	24,516,203	2	14.81%
BANKERS L&C	16,181,953	3	8.71%	15,199,445	3	9.18%
PHYS. MUT. LIFE	14,042,314	4	7.56%	11,752,906	4	7.10%
FAMILY HEALTH PL	11,992,426	5	6.45%	6,356,737	7	3.84%
SECURITY HLT PLA	11,408,296	6	6.14%	10,432,305	5	6.30%
UNITED AMERICAN	10,385,972	7	5.59%	9,876,841	6	5.97%
PRINCIPAL MUT	6,299,034	8	3.39%	5,648,592	8	3.41%
MUTUAL OF OMAHA	5,785,039	9	3.11%	5,605,123	9	3.39%
DEAN HEALTH PLAN	5,547,749	10	2.99%	3,683,629	10	2.23%
CENTRAL STATES	4,154,142	11	2.24%	1,555,806	15	0.94%
NATIONAL STATES	2,979,704	12	1.60%	2,845,865	11	1.72%
PIONEER LIFE	2,742,654	13	1.48%	576,745	22	0.35%
CNA	2,518,543	14	1.36%	2,290,377	12	1.38%
STATE FARM MUT	2,461,626	15	1.32%	1,344,040	17	0.81%
MIDELFORT CLINIC	1,819,304	16	0.98%	959,098	19	0.58%
COLONIAL PENN	1,779,580	17	0.96%			
AAL	1,773,323	18	0.95%	1,623,773	14	0.98%
GUARANTEE TRUST	1,551,711	19	0.84%	1,664,995	13	1.01%
RURAL	1,384,001	20	0.74%	1,426,392	16	0.86%
AM FAM LIFE ASSU	1,327,718	21	0.71%	367,968	30	0.22%
AMERICAN FAMILY	890,872	22	0.48%	608,542	21	0.37%
AMER. REPUBLIC	823,259	23	0.44%	526,370	23	0.32%
FEDERAL HOME	796,215	24	0.43%	981,045	18	0.59%
MED ASS HMO	758,219	25	0.41%	636,529	20	0.38%
PHYSICIANS PLUS	713,509	26	0.38%	462,249	27	0.28%
HMO OF WISCONSIN	682,182	27	0.37%	472,850	25	0.29%
GRT LA CROSSE	666,625	28	0.36%	310,935	32	0.19%
MIDAMERICA LIFE	588,723	29	0.32%	509,974	24	0.31%
TIME	470,952	30	0.25%	445,881	28	0.27%
FEDERAL LIFE	455,529	31	0.25%	255,098	34	0.15%
COMPCARE	443,416	32	0.24%	462,959	26	0.28%
GP HEALTH EAUCLA	364,560	33	0.20%	81,348	42	0.05%
NORTH CENTRAL	345,868	34	0.19%	197,688	36	0.12%
MUT. PROT. LIFE	287,312	35	0.15%	335,568	31	0.20%
BENEFIT TRUST	277,840	36	0.15%	371,305	29	0.22%
UNION LABOR LIFE	274,637	37	0.15%	298,150	33	0.18%
LUTH. BROTH.	256,342	38	0.14%	190,708	37	0.12%
NEW YORK LIFE	198,409	39	0.11%	240,585	35	0.15%
CONT GENERAL	136,345	40	0.07%	83,624	41	0.05%
PEKIN LIFE	123,452	41	0.07%	101,299	40	0.06%
NATIONAL HOME	109,334	42	0.06%	132,068	38	0.08%
GHC SOUTH CENTRA	104,186	43	0.06%		NO INFORMATION	
MEDICO LIFE	83,012	44	0.04%	128,709	39	0.08%
WIS HEALTH ORG	69,095	45	0.04%	30,203	44	0.02%
NORTH AMERICAN	55,362	46	0.03%			
GLOBE L&A	37,384	47	0.02%	75,074	43	0.05%
NATL TRAV LIFE	19,779	48	0.01%	19,510	45	0.01%
HMO MIDWEST	15,587	49	0.01%			
NATL CASUALTY	15,327	50	0.01%	18,112	46	0.01%
COMBINED INS	15,117	51	0.01%			
AMERICAN INCOME	0	52	0.00%	8,681	47	0.01%
PENN LIFE	0	53	0.00%	7,901	48	0.00%
LUMBERMEN'S	0	54	0.00%	4,485	49	0.00%
MASS INDEMNITY	0	55	0.00%	2,414	50	0.00%
AMER. MOTORISTS	0	56	0.00%	750	51	0.00%
TOTAL	$185,821,404		100.00%	$165,516,454		100.00%

1987 WISCONSIN MEDICARE SUPPLEMENT EXPERIENCE DATA

	COMPANY	EARNED PREMIUM	INCURRED LOSSES	LOSS RATI TOTAL
1	BC/BS OF WIS.	49,739,000	29,539,000	59.39%
2	WPS	24,516,203	18,051,417	73.65%
3	BANKERS L&C	15,199,445	9,337,759	61.43%
4	PHYS. MUT. LIFE	11,752,906	9,190,125	78.19%
5	SECURITY HLT PLA	10,432,305	7,632,249	73.16%
6	FAMILY HEALTH PL	6,356,737	4,375,559	68.83%
7	PRINCIPAL MUT	5,648,592	4,202,200	74.39%
8	MUTUAL OF OMAHA	5,605,123	3,571,944	63.73%
9	DEAN HEALTH PLAN	3,683,629	3,868,235	105.01%
10	NATIONAL STATES	2,845,865	1,085,060	38.13%
11	CNA	2,291,527	1,561,029	68.16%
12	GUARANTEE TRUST	1,664,995	714,729	42.93%
13	AAL	1,623,775	1,240,849	76.42%
14	CENTRAL STATES	1,555,306	641,186	41.21%
15	RURAL	1,426,392	899,185	63.04%
16	STATE FARM MUT	1,344,040	773,402	57.54%
17	FEDERAL HOME	981,045	516,977	52.70%
18	MIDELFORT CLINIC	959,098	926,278	96.58%
19	MED ASS HMO	636,529	530,569	83.35%
20	AMERICAN FAMILY	608,542	303,968	49.95%
21	PIONEER LIFE	576,745	308,443	53.48%
22	AMER. REPUBLIC	526,370	206,075	39.15%
23	MIDAMERICA LIFE	509,974	263,114	51.59%
24	HMO OF WISCONSIN	472,850	400,859	84.78%
25	COMPCARE	462,959	253,322	54.72%
26	PHYSICIANS PLUS	462,249	406,779	88.00%
27	TIME	445,881	127,753	28.65%
28	BENEFIT TRUST	371,305	227,011	61.14%
29	AM FAM LIFE ASSU	367,968	96,833	26.32%
30	MUT. PROT. LIFE	335,568	260,968	77.77%
31	GRT LA CROSSE	310,935	178,257	57.33%
32	UNION LABOR LIFE	298,150	233,013	78.15%
33	FEDERAL LIFE	255,098	143,966	56.44%
34	NEW YORK LIFE	240,585	123,377	51.28%
35	NORTH CENTRAL	197,688	142,235	71.95%
36	LUTH. BROTH.	190,708	101,827	53.39%
37	NATIONAL HOME	132,068	84,292	63.82%
38	MEDICO LIFE	128,709	69,737	54.18%
39	PEKIN LIFE	101,299	47,244	46.64%
40	GHC SOUTH CENTRA	99,576	42,493	42.67%
41	CONT GENERAL	83,624	24,013	28.72%
42	GP HEALTH EAUCLA	81,348	70,332	86.46%
43	WIS HEALTH ORG	30,205	34,075	112.82%
44	NATL TRAV LIFE	19,510	1,174	6.02%
45	NATL CASUALTY	18,112	10,683	58.98%
46	AMERICAN INCOME	8,681	5,379	61.96%
47	PENN LIFE	7,901	4,909	62.13%
48	LUMBERMEN'S	4,485	(23,407)	-521.90%
49	MASS INDEMNITY	2,414	137	5.68%
50	AMER. MOTORISTS	750	162	21.60%
51	UNITED AMERICAN	0	0	ERR
52	GLOBE L&A	0	0	ERR
	TOTAL	155,564,539	102,764,282	66.06%

Colonial Penn Life Insurance Company

Colonial Penn Plaza/19th & Market Sts./Philadelphia, PA 19181

A STOCK COMPANY also referred to in this policy as COLONIAL PENN

HOSPITAL CONFINEMENT INDEMNITY POLICY

This policy provides a daily benefit for covered hospital confinements. The daily benefit amount is shown in the SCHEDULE OF BENEFITS. Please read your entire policy carefully.

WHO IS COVERED

COLONIAL PENN certifies that the person who is named on the POLICY SCHEDULE and for whom the premium has been paid is covered. The terms "you" and "your" refer to the person named.

YOUR INSURANCE POLICY

This policy is a contract between Colonial Penn and you. Payment of the premium puts this policy in force on the Effective Date shown on the POLICY SCHEDULE for the period for which premium is paid. Colonial Penn will pay benefits for covered confinements and care which result from sickness or injury, as provided in this policy.

GUARANTEED RENEWABLE/RATE CHANGE

You may renew this policy by paying the premium when due or during the 31-day grace period that follows. Colonial Penn cannot refuse to renew your policy.

Your premium is based on your age on the Effective Date of this policy. Colonial Penn can change the premium rates for this policy, but only if the same change is made for all persons of your class and state who are covered under policy form series 4-82-363. Any change in your premium will take effect only on an anniversary of your Effective Date. Colonial Penn will notify you of any change in your premium.

NOTICE OF YOUR RIGHT TO EXAMINE THIS POLICY FOR 30 DAYS

If you decide that you do not want this policy, you may return it to Colonial Penn, or to the agent through whom it was purchased, within 30 days after you receive it. Colonial Penn will then refund any premium paid. If returned, this policy will never have been in effect.

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR INSURANCE

Please read the copy of the application attached to your policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to Colonial Penn Life Insurance Company, Colonial Penn Plaza, 19th & Market Sts., Philadelphia, PA 19181 within 10 days if any information shown on the application is not correct and complete or if any medical history has not been included. The application is part of the insurance contract. The insurance contract was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

Countersignature _____

(Licensed Resident Agent where required by law)

FORM FILING APPROVED
EFFECTIVE: 2/19/88
Commissioner of Insurance
State of Wisconsin

4-82-363(WI)

2/4/88

Colonial Penn Life Insurance Company
Colonial Penn Plaza 19th & Market Sts./Philadelphia, Pennsylvania 19181

EXHIBIT 2

This policy is not designed to fill the gaps in Medicare. It will pay you only a fixed dollar amount per day when you are confined to a hospital. For more information, see "Health Insurance Advice for Senior Citizens", given to you when you applied for this policy.

SAMPLE OF DISCLOSURE THAT MUST BE ATTACHED TO FACE OF HOSPITAL INDEMNITY POLICY WHEN MARKETED TO MEDICARE ELIGIBLE.

COVERAGE REQUIREMENTS

Hospital Confinement

Colonial Penn will pay the Daily Benefit shown in the SCHEDULE OF BENEFITS if you are confined in a *hospital* as an inpatient. To be covered, the *hospital* confinement must:

1. begin while your coverage is in force; and
2. be required for the treatment of your *sickness* or *injury;* and
3. be *medically necessary* and recommended by your *physician.*

The maximum number of days payable is determined by adding together all covered days of confinement during a *period of confinement.* The maximum number of days payable during a *period of confinement* is shown in the SCHEDULE OF BENEFITS.

The Daily Benefit will not be paid for the day of discharge unless the *hospital* makes an inpatient room and board charge for that day.

Limitation: Government Hospital Confinement

Colonial Penn will pay the Daily Benefit shown in the SCHEDULE OF BENEFITS for up to a maximum of 120 days during a *period of confinement* if you are confined in any of the following:

1. a military or veterans hospital; or
2. any hospital contracted for, or operated by, any national government or agency for the treatment of members or ex-members of the armed forces.

The Daily Benefit will not be paid for the day of discharge from any of the above unless the *hospital* makes an inpatient room and board charge for that day.

WHAT IS NOT COVERED

War

Loss caused by or resulting from war or any act of war whether declared or undeclared is not covered.

Care Outside U.S.A.

Confinement occurring outside the United States or its possessions is not covered.

Mental Illness

Confinement for the treatment of mental, psychoneurotic or personality disorders, without demonstrable organic disease, is not covered.

Other Coverage with Colonial Penn

You may have coverage with Colonial Penn under more than one policy providing hospital confinement indemnity benefits. However, the aggregate of the initial daily benefit amounts payable under all policies may not exceed $150 per day, if you are under age 65 on this policy's Effective Date, or $100 per day if you are age 65 or over on the Effective Date. If the aggregate exceeds $150 per day ($100 per day if you are age 65 or over) part or all of the coverage of this policy will be void. The premium paid for any coverage which is voided shall be returned to you.

BENEFITS AFTER THIS POLICY TERMINATES

If you are confined in a *hospital* on the date this policy terminates, benefits will be paid as though this policy had not terminated, but only while you remain continuously confined.

POLICY DEFINITIONS

Hospital

"Hospital" means an institution which meets all of the following requirements: (a) holds a State license as a *hospital* (if a license is required) and operates pursuant to law; (b) is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the *hospital* on a pre-arranged basis and under the supervision of a staff of duly licensed *physicians*, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis; and (c) provides 24-hour nursing service by or under the supervision of registered graduate professional nurses (RN's).

Note: An institution which is: 1) primarily a clinic, nursing home, rest or convalescent home; or 2) other than incidentally, a place for the treatment of alcoholics or drug addicts will *not* be considered a *"hospital"*. Confinement in a *hospital* unit or area which functions primarily as a skilled nursing facility or other type of nursing home, rest or convalescent home will *not* be considered *"hospital"* confinement.

Injury

"Injury" means bodily injury caused by an accident.

Medically Necessary

A *hospital* confinement is *"medically necessary"* when you have a medical condition which requires a degree and frequency of medical services and treatment which can be provided only in a *hospital* on an inpatient basis.

Period of Confinement

"Period of Confinement" means continuous or intermittent confinement as an inpatient in a *hospital*. A *"period of confinement"*: 1) begins on the day you are admitted as an inpatient in a *hospital;* and 2) ends on the day when 60 consecutive days have passed during which time you have not been confined in a *hospital*. Confinements not separated by 60 consecutive days are considered one *"period of confinement"*.

Physician

"Physician" means a licensed practitioner of the healing arts acting within the scope of his/her license. The *"physician"* cannot be: 1) someone who ordinarily resides in your home; or 2) you or your spouse; or 3) your or your spouse's child, brother, sister or parent.

Sickness

"Sickness" means an illness or disease.

WHEN YOU HAVE A CLAIM

Notice of Claim

You must notify Colonial Penn in writing when you have a claim. Your written notice must be provided within 20 days after the loss begins or occurs, or as soon as is reasonably possible. Notice given by you or by someone else on your behalf with enough information to identify you shall be considered as sufficient notice to Colonial Penn when mailed to its Health Claims Department, Colonial Penn Plaza, 19th & Market Sts., Philadelphia, Pennsylvania 19181, or when given to an agent of Colonial Penn.

Claim Forms

When Colonial Penn receives written notice of your claim, it will send claim forms to you to file your proof of loss. If claim forms are not sent to you within 15 days after you have notified Colonial Penn of your claim, you may provide proof of loss within the time limits stated in the "Proofs of Loss" paragraph by sending Colonial Penn written proof of the occurrence, character and extent of your loss.

Proofs of Loss

You must provide Colonial Penn with written proof of your loss within 90 days after the date of your loss. If it is not reasonably possible to furnish the necessary proof within the 90 days, a claim will not be reduced or denied solely because of failure to do so. The necessary proof must, however, be furnished as soon as reasonably possible, and not later than one year from the end of the 90-day period. The one year limit will be extended indefinitely while you are not legally capable of furnishing sufficient proof.

Time of Payment of Claim

After you have filed sufficient proof of loss, all benefits will be paid as they become due.

Payment of Claim

All benefits will be paid to you. You may, however, direct Colonial Penn in writing to pay your benefits directly to the person or institution providing the care.

Any benefit unpaid at your death will be paid to your estate. If any benefit is payable to your estate or while you are not competent to give a valid release, Colonial Penn may pay a benefit up to One Thousand Dollars ($1,000) to any relative Colonial Penn decides to be justly entitled to it. Any payment made to your relative in good faith will fully release Colonial Penn of its responsibility only to the extent of the payment.

Physical Examination

When you submit a claim, Colonial Penn has the right to have you examined, at its own expense, when and as often as it may reasonably require while your claim is being considered or during any period for which benefits are being paid by Colonial Penn.

Legal Actions

You cannot bring any action at law or in equity for any benefits under this policy until 60 days after you have filed written proof of your loss.

No such action can be brought after 3 years from the date you were required to file proof of your loss.

Misstatement of Age

If your age is misstated, the amount of any overpayment of premium will be refunded to you, or the amount of any underpayment of premium is due to Colonial Penn.

GENERAL MATTERS

Time Limit On Certain Defenses

Misstatements in the application: Up to 2 years after the Effective Date, misstatements in your application can be used to void the policy or deny any claim; and, after 2 years from the Effective Date, only fraudulent misstatements in your application can be used to void the policy or deny any claim for loss incurred after such 2-year period.

Premium Payment

Premium must be paid when due. Premium is payable to Colonial Penn.

Grace Period

If any premium after the first premium is not paid when due, it may be paid during the following 31 days. During the grace period, this policy will stay in force. At the end of the grace period, this policy will terminate. If your policy terminates, benefits otherwise payable under the terms of this policy will be provided for the duration of any covered confinement which began while your policy was in force.

Entire Contract Changes

This policy with the attached application and papers, if any, is the entire contract between you and Colonial Penn. No change in this policy will be effective until approved by a Colonial Penn officer. This approval must be noted on or attached to this policy. No agent or other person may change this policy or waive any of its provisions.

Reinstatement

You may reinstate this policy if the policy terminates for non-payment of premium. Payment of the premium to Colonial Penn (or to an agent authorized to accept premium) will reinstate this policy. However, you may be required to complete an application for reinstatement.

If Colonial Penn or its agent requires you to complete an application, you will be given a conditional receipt for the premium. If your application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 30th day after the date of the conditional receipt unless Colonial Penn has previously notified you in writing of its disapproval.

Your reinstated policy will cover only confinement and care that result from an injury sustained or sickness that starts after the date of reinstatement. In all other respects the rights of you and Colonial Penn will remain the same, subject to any provisions noted on or attached to your reinstated policy.

Signed for Colonial Penn Life Insurance Company by its president and secretary in Philadelphia, Pennsylvania.

Secretary *President*

POLICY INDEX

HOSPITAL CONFINEMENT INDEMNITY POLICY

POLICY SCHEDULE

Issued to: ••••••••••••••••••••••
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Date of Birth: ########

Policy Number: ##########
Effective Date: ########

Initial Premium: ••••••••••••••••••••••••••

SCHEDULE OF BENEFITS

This SCHEDULE OF BENEFITS is a brief outline of your coverage. Please read your entire policy carefully for a full description of your coverage.

HOSPITAL CONFINEMENT (during any one period of confinement)	DAILY BENEFIT
Days 1 through 365	••••••• per day
Days 366 and after	No Benefit

INDIVIDUAL HOSPITAL CONFINEMENT INDEMNITY APPLICATION

COLONIAL PENN LIFE INSURANCE COMPANY
PHILADELPHIA, PENNSYLVANIA 19181

HOME OFFICE USE ONLY

Special Instructions

Policy applied for: [Daily Benefit $ XX.XX]

1. Name: [JOHN DOE] 2. DOB: [2-18-22] 3. Age: [45] 4. Sex: [☒M ☐F]
5. Address: [123 MAIN ST. ANYTOWN USA 00000] 6. Phone #: [123-4567]
(No. and Street) (City) (State) (Zip Code)

7. Are you covered under another policy not being replaced by the policy you are now applying for, that provides Daily Hospital Confinement benefits (other than Medicare or Medicare Supplement Insurance)? ☐YES [☒NO]

If yes, Company Name: _____

Policy Number: _____

Daily Benefit: _____

8. Is the policy applied for intended to replace any Hospital Confinement Indemnity policy which you plan to terminate? ☐YES [☒NO]

If yes, company name: _____

Address: _____

Policy Number: _____

IF THE ANSWER TO EITHER QUESTION 9 OR 10 IS YES, THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE.

9. Have you been confined as an in-patient in a hospital, nursing home, facility for mental or nervous disorders, or other medical facility within the last 6 months? ☐YES [☒NO]

10. Has confinement or surgery been recommended or discussed by your physician within the last 6 months? ☐YES [☒NO]

11. Name and address of personal physician:

JOHN SMITH

895 SPRUCE ST.

ANYTOWN, USA 00000

12. Premium: ☐ A $ _____ [☒ SA $ XX.XX] ☐ Q $ _____ ☐ Other _____ $ _____ Policy Fee: [$ XX.XX]

Paid with application: [$ XX.XX] If spouse application submitted concurrently, his/her name: _____

13. I apply to Colonial Penn Life Insurance Company for a policy to be issued in reliance on my written answers to the above questions. The answers are true to the best of my knowledge and belief. I understand that a copy of this application will be attached to and become a part of my policy and that a false statement or answer, which materially affects the acceptance of the risk or hazard assumed by Colonial Penn, can be used to void the policy as of its effective date or to deny a claim. I have received an outline of coverge for the policy applied for and if eligible for Medicare, a Medicare Supplement Buyer's Guide.

I authorize any insurance company, hospital, medical or medically related facility, physician or other medical practitioner or any other organization, institution or person that has any records or knowledge of me or my health to give to Colonial Penn Life Insurance Company and its underwriters any such information.

I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 30 months from the date signed. I further understand that, upon request, I or an authorized representative have a right to receive a copy of this authorization.

I understand and agree that no coverage shall be in force until the policy is issued, and if issued, that coverage will be effective on the date shown in the Policy Schedule.

Applicant's signature: X [John Doe] Date: [8/4/87]

Application signed at: [Anytown] [PA] [USA] [00000]
(City) (State) (Zip)

APPROVED 2/17/88 Colonial Penn Life Insurance Co. Philadelphia, Pennsylvania

You will be notified within 60 days as to whether this application has been accepted or rejected or the reason for any delay.

I certify: (1) I have accurately recorded the information supplied by the applicant; (2) I have given to the applicant an outline of coverage for the policy applied for and if eligible for Medicare, a Medicare Supplement Buyer's Guide.

Agent's signature: X [James Doe] Agent number: [895-43]

Agent's name and address: [345 MAIN ST ANYTOWN USA 00000]

A check or money order for the first premium and policy fee, made payable to CPLIC, must accompany application.

4-82-364

Colonial Penn Life Insurance Company
Colonial Penn Plaza / 19th & Market Sts. / Philadelphia, PA 19181

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Colonial Penn Life Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, certain facts should be pointed out to you which should be considered before you make this change.

1. Health conditions which you may presently have may not be covered under the new policy. This could result in a claim for benefits being denied which may have been payable under your present policy.
2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.
4. The new policy will be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.
5. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.
6. It may be to your advantage to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

Colonial Penn Life Insurance Company
Colonial Penn Plaza / 19th & Market Sts. / Philadelphia, Pennsylvania 19181

HOSPITAL CONFINEMENT INDEMNITY COVERAGE OUTLINE OF COVERAGE

1. **Read Your Policy Carefully:** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. **Hospital Confinement Indemnity Coverage** is designed to provide you with a fixed daily benefit during periods of hospital confinement resulting from a covered injury or sickness. A covered injury or sickness must begin while your coverage is in force and be medically necessary and recommended by your physician. Coverage is provided only for the benefits outlined below, subject to any limitations as set forth in the policy.

3. **Benefits:**

   Hospital Confinement Daily Benefit
   $[XX.XX] per day beginning on the first day of hospital confinement during any one period of hospital confinement.

   Maximum Benefit: 365 days per period of confinement. A new period of confinement begins after 60 consecutive days without hospitalization.

4. **Exclusions/Limitations:**

   a) **War:** Confinements for the treatment of an injury or sickness due to any act of war (whether declared or undeclared) are not covered.

   b) **Confinement outside U.S.A.:** Confinements and care received outside the United States or its possessions are not covered.

   c) **Mental Illness:** Confinements for the treatment of mental, psychoneurotic or personality disorders without demonstrable organic disease are not covered.

   d) **VA or Governmental Hospitals** - Benefits for confinements in a V.A. or Government Hospital are paid for up to a maximum of 120 days per period of confinement.

   e) **Other Coverage with Colonial Penn** - You may have coverage with Colonial Penn under more than one policy providing hospital confinement indemnity benefits. However, the aggregate of the initial daily benefit amounts payable under all policies may not exceed $150 per day. If the aggregate exceeds $150 per day part or all of the coverage of this policy will be void. The premium paid for any coverage which is voided will be returned to you.

5. **Guaranteed Renewability:** You may renew this policy by paying the premium when due or during the 31-day grace period that follows. Colonial Penn cannot refuse to renew your policy.

6. **Premium:** Your premium is based on your age on the Effective Date of this policy. Colonial Penn can change the premium rates for this policy, but only if the same change is made for all persons of your class and state who are covered under policy form series 4-82-363. Any change in your premium will take effect only on an anniversary of your Effective Date.

7. **Initial Premium Rates:**

Age:	
____	50 - 54
____	55 - 59
_X_	60 - 64

Premium Mode:	
Other	$ _____
Quarterly	$ XXX.XX
Semi-Annual	$ _____
Annual	$ _____

If you and your spouse apply at the same time and you are both approved, your premiums will be reduced by 5%.

8. **Policy Fee:** A policy fee of $20.00 is payable at the time of application.

Exhibit 3

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, Wisconsin 53707-7873

OCI
OFFICE OF THE COMMISSIONER OF INSURANCE

HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS

For more information on health insurance call:

MEDIGAP HOTLINE
1-800-242-1060

This is a statewide toll-free number set up by the Wisconsin Board on Aging and Long Term Care and funded by the Insurance Commissioner's Office to answer questions about health insurance and other health care benefits for the elderly. It has no connection with any insurance company.

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, Wisconsin 53707-7873
January 1989

For information on filing an insurance complaint call:
"Insurance Complaint Hotline"
1-800-362-3020

PI-2 (10/88)

TABLE OF CONTENTS

INTRODUCTION

This booklet briefly describes the Medicare program. It also describes the health insurance available to those on Medicare. A list of the individual Medicare supplement policies currently being sold in Wisconsin may be obtained by sending a large, stamped, self-addressed envelope to:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

If you have questions or concerns about your insurance company or agent, write to the insurance company or agent involved. Keep a copy of the letter you write. If you do not receive satisfactory answers please contact:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0103

For information on filing a complaint with the Insurance Commissioner's Office call:

"Insurance Complaint Hotline"
1-800-362-3020

MEDICARE AND MEDICARE "GAPS"

Medicare is the health insurance program administered by the federal Health Care Financing Administration for people over 65 and for some people under 65 who are disabled. It pays many health care costs for eligible persons. The chart on the following page gives a *brief outline* of those costs which Medicare does and does not pay.

Medicare is divided into two types of coverage. Hospitalization Insurance (Part A) pays hospital bills and certain skilled nursing facility expenses. Medical Insurance (Part B) pays doctors' bills and certain other charges.

Beginning in January 1989, there will be several changes in the Medicare program. The changes in 1989 will affect only the Part A coverage for hospital and skilled nursing facility care. In 1990 there will be changes in Part B—including placing a cap on out-of-pocket expenses for certain Part B benefits and beginning some coverage for outpatient prescription drugs. In 1991, more extensive coverage of outpatient prescription drugs will be added. The changes which will take effect in 1989 are described in the chart on page 4. Changes which will take place in 1990 and the following years will be described in detail in later editions of this booklet.

A booklet entitled *Your Medicare Handbook* is available free from any Social Security office. It gives a detailed explanation of Medicare.

Compare the items Medicare will not pay with the insurance policy you are considering. The deductible figures are for 1989 only.

ATTENTION: Medicare pays for covered services which are medically necessary. The amount paid by Medicare is based on the "Medicare-approved" charge for the service. This amount is often less than the amount you are charged by a doctor or other provider. It is sometimes referred to as the "reasonable" or "allowable" charge.

Sometimes a provider or health care plan accepts "assignment." This means that the doctor or health care plan will be paid directly by Medicare and will accept the "Medicare-approved" amount as full payment. A list of doctors in Wisconsin who accept assignment is available from Wisconsin Physicians Service, 1717 W. Broadway, Madison, Wisconsin 53713 or may be reviewed at your local Social Security office. The State Medical Society and the Coalition of Wisconsin Aging Groups operate "Partnercare" — a program through which doctors agree to accept assignment for low-income patients. For more information on this program, contact the State Medical Society, 330 E. Lakeside St., Madison, WI 53715 or your County Commission on Aging.

SKILLED NURSING CARE: Medicare pays limited benefits in a skilled nursing facility approved by Medicare if you need skilled nursing care as directed by Medicare. MEDICARE DOES NOT PAY FOR PERSONAL CARE SUCH AS EATING, BATHING, DRESSING, OR GETTING IN OR OUT OF BED. MOST NURSING HOME CARE IS NOT COVERED BY MEDICARE! For more information, send a stamped, self-addressed envelope to the Insurance Commissioner's Office and ask for the "Buyers Guide to Long Term Care."

PART A — HOSPITAL INSURANCE BENEFITS

HOSPITAL INPATIENT (Semi-private Room and Board, General Nursing, and Miscellaneous Hospital Services)
FOR EACH CALENDAR YEAR

Initial Deductible:	YOU PAY THE FIRST $560. Medicare pays the balance for up to 365 days each calendar year.
SKILLED NURSING FACILITY (Skilled nursing care in a Medicare-certified facility if you qualify)	
First 8 days:	Medicare pays all but $25.50 a day.
9th to 150th day:	Medicare pays the entire cost.
After 150th day:	YOU PAY ALL COSTS.
INPATIENT PSYCHIATRIC CARE	Medicare pays the same as other hospitalization, up to a lifetime maximum of 190 days. YOU PAY ALL COSTS AFTER 190 DAYS.
HOME HEALTH CARE Home Health Care	Medicare pays for a limited number of visits which are considered medically necessary by Medicare. Medical necessity is narrowly defined and you will need to meet other criteria before qualifying for benefits.

PART B — MEDICAL INSURANCE BENEFITS

Physicians' Services Inpatient and Outpatient	EACH CALENDAR YEAR YOU PAY A $75 DEDUCTIBLE AND 20% OF ALL MEDICARE-APPROVED CHARGES.
Outpatient Medicare Services and Supplies	Medicare pays 80% of the approved charges.
Outpatient Physical and Speech Therapy	
Ambulance	

NOTE: UNLESS YOUR DOCTOR OR OTHER HEALTH CARE PROVIDER ACCEPTS MEDICARE ASSIGNMENT, YOU ARE RESPONSIBLE FOR ANY CHARGES WHICH ARE HIGHER THAN THOSE APPROVED BY MEDICARE. YOU ARE ALSO RESPONSIBLE FOR ANY SERVICES WHICH MEDICARE CONSIDERS UNNECESSARY.

Outpatient Psychiatric Care	Medicare pays the same as for other physicians' services but benefits are limited. YOU PAY ALL COSTS IN EXCESS OF THE LIMIT ($1,375 in 1989), PLUS THE $75 DEDUCTIBLE, 20% OF APPROVED CHARGES, AND THE CHARGES WHICH ARE HIGHER THAN THOSE APPROVED BY MEDICARE.
Home Health Care	Medicare only pays for up to 38 consecutive days of home health visits which are considered medically necessary by Medicare.
Blood	YOU PAY FOR THE FIRST 3 PINTS AND 20% AFTER THAT. Medicare pays 80% after the first 3 pints of blood.
Custodial Care in a Nursing Home, Dental Care, Eye Care, Hearing Aids, Routine Check-ups	YOU PAY FOR ALL THESE ITEMS.

TYPES OF COVERAGE

There are several ways to buy health insurance policies after you turn 65. Some people continue the coverage they had before turning 65 with a change in benefits. Others buy group or individual insurance policies. Others are eligible for Medical Assistance, a program which provides health care for low-income people, and do not need to buy private insurance. There is no one answer which is right for everyone and finding the right coverage at an affordable price may be difficult.

GROUP INSURANCE

There are two types of group insurance available. The first is bought through an employer. The second is bought through a voluntary association.

Employer group: Many people have group health insurance while they are employed. If you have group coverage, find out before you retire if it can be continued or converted to suitable Medicare supplement coverage when you reach 65.

Both state and federal law require many employers to offer continued health insurance benefits to people whose group coverage ends because of divorce, death of a spouse or termination of employment for reasons other than discharge for misconduct. Check with your employer for more information.

If your spouse is included in your group plan, find out what happens if he or she reaches 65 before you do. If you request it, the insurer must give you a written explanation of the benefits you will have after you become eligible for Medicare.

If you continue to work after age 65, be sure to ask your employer about federal regulations relating to Medicare and group health insurance policies. Your local Social Security office also has information on "Medicare as Secondary Payor."

REMEMBER: Employer group coverage is often available regardless of your health and usually does not include any waiting periods for pre-existing conditions.

Voluntary Associations: A number of organizations, such as associations of retired persons, offer "group" health insurance to members over age 65. The value of these plans differs. Some appear to give low rates but actually cost more than comparable individual policies. These plans are not as strictly regulated by the state as other policies and you should be sure that you understand the benefits. The checklist on the inside back cover may be used to compare these policies.

INDIVIDUAL INSURANCE

If you do not have adequate group insurance and are not eligible for Medical Assistance, you may want to buy an individual policy. There are two types of individual policies available — Medicare Supplements and Medicare Replacements. These are described below.

MEDICARE SUPPLEMENTS

Medicare Supplements are available both from traditional insurers and from health maintenance organizations (HMOs). HMOs are prepaid health plans. You pay the HMO a set amount each month for all covered services. You must use the doctors and hospitals which are connected to the plan. You will have less paperwork to worry about if you join an HMO.

With a traditional insurance plan, you are billed for each service you receive and you are permitted to go to any doctor. You will have to submit your claim to the insurer for payment.

Prior to January 1, 1989, all individual Medicare supplement policies sold in Wisconsin fit into one of three categories. The categories were: Medicare Supplement 1, Medicare Supplement 2, and Medicare Supplement 3.

Beginning on January 1, 1989, there will be only one type of Medicare supplement — a basic Medicare supplement policy. Insurers will be permitted to add a limited number of specified additional benefits to the basic policy. The minimum required benefits and the optional additional benefits are described on the charts on pages 10, 11 and 12, 13.

IMPORTANT NOTICE

The changes in Medicare supplement policies do not mean that you should give up a policy you bought before January 1, 1989. These policies will be modified by the insurer to eliminate any duplication with Medicare. Your insurance company will notify you each year about these modifications.

MEDICARE REPLACEMENTS

A Medicare replacement policy is a special arrangement between the federal Health Care Financing Administration (HCFA) and certain HMOs. Under these arrangements the federal government pays the HMO a set amount for each Medicare enrollee. The HMO agrees to provide all Medicare benefits. The HMO will also provide some additional benefits at additional cost. These are sometimes referred to as "Medicare direct risk contracts." Enrollees continue to pay their Part B premium to HCFA.

Anyone who enrolls in an HMO which has a risk contract with HCFA is "locked in." This means that, except for emergency or urgent care situations away from home, enrollees must receive all services, including Medicare services, from HMO providers. If you go to a doctor or hospital who does not belong to your HMO without a referral from your physician, you will be responsible for the entire cost of the services you receive including Medicare costs.

EMERGENCY AND URGENTLY NEEDED SERVICES

Emergency services are defined by the federal government as covered inpatient or outpatient medical and other services provided by an appropriate source within or outside the HMO's service area, which may not be delayed until HMO providers or services can be used without risk or permanent damage to the patient's health.

Such services must be needed immediately to prevent the death of the enrollee or serious impairment of his or her health.

Urgently needed services are "covered services which enrollees require to prevent a serious deterioration of an enrollee's health that results from an unforeseen illness or injury if the enrollee is temporarily absent from the organization's geographic area and receipt of the health care service cannot be delayed until the enrollee's return to the organization's geographic area."

Anyone who enrolls in a Medicare replacement policy may disenroll at any time. Disenrollment will become effective four to six weeks after the HMO is notified that you want to disenroll. At the time your disenrollment is effective, any unused premium will be returned to you. After your disenrollment is effective, you will again be eligible for regular Medicare and, if you want coverage for Medicare "gaps" you will need to buy a separate supplement policy.

REMEMBER: If you buy either a Medicare supplement or a Medicare replacement policy from a health maintenance organization, you will not have to file claims. Except for out of area claims, the HMO will take care of all your paperwork. You also do not have to worry about the difference between Medicare's approved charge and the actual charge.

MEDICARE SUPPLEMENT POLICIES

MEDICARE PART A BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	BASIC MEDICARE SUPPLEMENT POLICY PAYS	OPTIONAL ADDITIONAL BENEFITS***
HOSPITALIZATION. Semi-private room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthetics and rehabilitation services.	First $560	Nothing	Nothing	1. $560 deductible
	After first $560	100% of costs	Nothing	Nothing
POSTHOSPITAL SKILLED NURSING CARE.* In a facility approved by Medicare if you meet Medicare's criteria.	First 8 days	All but $25.50 a day.	$25.50 a day	Nothing
	9th to 150th day	100% of costs	Nothing	Nothing
	150th to 365th day	Nothing	100% of costs	Nothing
INPATIENT PSYCHIATRIC CARE. In a participating psychiatric hospital.	190 days per lifetime	Same as other hospital	175 days per lifetime in addition to Medicare	Nothing
	After 190 days	Nothing		Nothing
BLOOD. While hospitalized.		All but first three pints	First 3 pints	Nothing
HOME HEALTH CARE.**		All visits considered medically necessary by Medicare	40 visits in addition to those paid by Medicare	2. 365 visits including those paid by Medicare

***See Page 14 for more information on optional additional benefits.

MEDICARE PART B BENEFITS	MEDICARE SUPPLEMENT POLICIES PER CALENDAR YEAR	MEDICARE PAYS	BASIC MEDICARE SUPPLEMENT POLICY PAYS	OPTIONAL ADDITIONAL BENEFITS***
MEDICAL EXPENSES. Eligible expenses for physicians' services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy and outpatient psychiatric care.	First $75 After first $75	Nothing 80% of Medicare's approved charge Note: There is a limit on outpatient psychiatric care	Nothing 20% of Medicare's approved charge	3. $75 deductible 4. The difference between Medicare's approved charge and the usual and customary charge as determined by the insurer
OUTPATIENT PRESCRIPTION DRUGS. Which you buy yourself.****		80% of approved charges for immunosuppressive drugs in 1st year after a transplant	Nothing	5. 75% of outpatient prescription drugs
MINIMUM CALENDAR YEAR POLICY LIMITS. For benefits to supplement Medicare Part B.		No limit	$10,000	

***See Page 14 for more information on optional additional benefits.

* Medicare supplement policies also include 30 days of skilled nursing care in a skilled nursing facility. The facility does not need to be certified by Medicare and the stay does not have to meet Medicare's definition of skilled care.

** HOME HEALTH CARE. Medicare provides for all medically necessary home health visits. However, medical necessity is defined quite narrowly, and you must meet certain other criteria. All Medicare supplement policies will pay up to 40 home care visits per year in addition to those provided by Medicare, if you qualify. You physician must certify that you would need to be in the hospital or a skilled nursing home if the home care was not available to you. Home nursing and medically necessary home health aide services are covered on a part-time or intermittent basis, along with physical, respiratory, occupational, or speech therapy.

Insurers are required, at the request of the insured, to provide coverage for 365 home health care visits in a policy year. Insurers may charge an additional premium for the additional coverage.

*** OPTIONAL ADDITIONAL BENEFITS. These optional benefits may either be included in the basic policy or sold as separate riders to a basic policy. If sold as separate riders, they will have the following titles:

1. Part A deductible rider;
2. Additional home health care rider;
3. Part B deductible rider;
4. Part B usual and customary charges rider;
5. Outpatient prescription drug usual and customary charges rider.

Insurers may also offer benefits for preventive health services and for services you receive while travelling in a foreign country.

**** PRESCRIPTION DRUGS. Drugs which are furnished by a hospital or skilled nursing facility, which cannot be self-administered, are covered if the hospital or skilled nursing home stay is covered by Medicare. Medicare benefits for outpatient prescription drugs are limited to immunosuppressive drugs in the first year after a transplant.

BUYING TIPS

NO INSURANCE POLICY WILL COVER EVERYTHING WHICH MEDICARE DOES NOT.

Medicare excludes certain types of medical expenses. *So do many Medicare supplement and Medicare replacement policies.*

Some items frequently excluded from these policies are: *custodial care in nursing homes, private duty nursing, routine check-ups, eye glasses, hearing aids, dental work, cosmetic surgery, and prescription drugs.* Some policies may include benefits for prescription drugs.

There are two other exclusions which are frequently misunderstood:

1. Medicare pays only for charges which are considered reasonable and services which are considered necessary. Medicare's determination of a reasonable, or "approved" charge may be much less than the actual charge for a covered service. Many Medicare supplement policies follow Medicare guidelines.

Medicare replacement and Medicare supplement policies offered by health maintenance organizations usually cover the entire charge for covered services and are not limited to coverage of Medicare-approved charges. Some non-HMO Medicare supplements may cover the entire charge.

2. Medicare pays for skilled nursing care in a skilled nursing facility approved by Medicare if your doctor certifies that it is necessary and you meet certain other criteria. There are no benefits for custodial care. In general Medicare supplements and Medicare replacements cover only skilled — not custodial or intermediate — care. Skilled nursing care is quite narrowly defined.

MANY POLICIES HAVE WAITING PERIODS, LIMITATIONS AND EXCLUSIONS.

Many health insurance policies have waiting periods before coverage begins. This waiting period may apply to those illnesses or physical disorders which are new or those which existed prior to the purchase of the policy, or both.

If the policy excludes pre-existing conditions for a limited time, that must be stated clearly in the policy. The waiting period for pre-existing conditions may not be longer than six months in a Medicare supplement, and only conditions treated during the six months before you take out the policy may be excluded. The waiting periods may be applied only to conditions which have not been disclosed on the application or which have been excluded by specific description.

REMEMBER: Some companies have "open enrollment" periods. This means that you will be accepted regardless of your health. However, there may be waiting periods before coverage begins. Health maintenance organizations which offer Medicare replacement policies are required by federal law to have a 30-day open enrollment period each year when any person on Medicare may enroll. There are no waiting periods for pre-existing conditions under Medicare replacement policies.

POLICY DELIVERY AND REFUNDS ON POLICIES SHOULD BE MADE PROMPTLY BY INSURANCE COMPANIES.

If you do not receive your policy within a month, or there is a delay in receiving a refund, call or write the insurance company.

IF YOU BUY FROM AN AGENT, FIND A GOOD LOCAL INSURANCE AGENT WHO CAN HELP YOU BUY THE RIGHT POLICY AND WILL ALSO ASSIST YOU WITH MAKING CLAIMS.

KEEP A COPY OF THE POLICY IN A SAFE PLACE.

It is a good idea to choose someone ahead of time who can take over your affairs in case of a serious illness. This person should know where your records are kept.

BUY ONLY ONE POLICY

Buying the most complete Medicare supplement or Medicare replacement policy you can afford is much better than buying several incomplete policies. Duplicate coverage is costly and unnecessary. This is true for both group and individual policies.

MEDICAL ASSISTANCE

Anyone eligible for Medical Assistance (Medicaid) does not need to buy private health insurance. This program pays almost all of the health care

costs for anyone who is eligible. For more information, contact your county social services department.

AN AGENT OR COMPANY MUST GIVE YOU AN OUTLINE OF COVERAGE WHEN SELLING YOU A NEW POLICY OR CONVERTING ONE YOU ALREADY OWN.

The Outline of Coverage is very important. It contains a chart summarizing the benefits provided by Medicare Parts A and B, and the Medicare supplement or replacement benefits provided by the policy. *The chart also shows which expenses are not covered by either.*

DO NOT BE MISLED BY AGENTS WHO INDICATE THAT YOUR MEDICAL HISTORY ON AN APPLICATION IS NOT IMPORTANT. OMITTING SPECIFIC MEDICAL INFORMATION ON YOUR APPLICATION CAN BE VERY COSTLY.

If your application for individual health insurance includes medical information, be sure that you answer *all* medical questions completely and accurately. If an agent helps you fill out the application, *do not* sign it until you read it. If you omit medical information and the insurance company finds out about it later, the company may deny your claim and/or terminate the policy.

If the application is part of the insurance contract, you will get a copy with the policy. Make sure that it has not been changed and that all the medical information is accurate.

POLICIES WHICH ARE GUARANTEED RENEWABLE OFFER ADDED PROTECTION.

Be sure to ask the agent or company about the renewability of the policy. If the policy is guaranteed renewable for life, it means that you can keep the policy as long as you pay the premium. It does not mean that the insurer won't raise the premium.

MAKE CHECKS PAYABLE ONLY TO THE INSURANCE COMPANY. DO NOT PAY CASH OR MAKE A CHECK OUT TO THE AGENT.

Be sure you have the agent's name, address and Wisconsin agent's license number and the name and address of the company from which you are buying the policy.

ASK YOUR DOCTOR ABOUT ASSIGNMENT.

If your doctor accepts assignment, you will not be charged more than the Medicare-approved charge for the services you receive. Most HMOs which offer Medicare supplement policies accept assignment for all services provided at the HMO. HMOs offering Medicare replacement policies accept assignment for all covered services.

ALMOST ALL INDIVIDUAL HEALTH INSURANCE POLICIES SOLD IN WISCONSIN HAVE A 10-DAY FREE LOOK.

Medicare supplement policies have a 30-day free look. If you are at all dissatisfied with a policy, you may return it to the company within this time and get a full refund. You should use the time to make sure the policy offers the benefits you expected. Check for any limitations, exclusions or waiting periods.

If you buy a Medicare replacement policy you will not have a "free look" period. However, if you enroll in a Medicare replacement policy you may disenroll at any time. Disenrollment will become effective four to six weeks after the HMO is notified that you want to disenroll. At the time your disenrollment is effective, any unused premium will be returned to you and you will be returned to regular Medicare.

LIMITED POLICIES

THESE POLICIES SHOULD NOT BE BOUGHT AS SUBSTITUTES FOR A COMPREHENSIVE MEDICARE SUPPLEMENT OR MEDICARE REPLACEMENT POLICY.

Nursing Home Coverage. There are now several nursing home insurance policies on the market in Wisconsin. These policies may not cover all types of nursing home care.

A Buyer's Guide to Long Term Care Insurance and a list of Nursing Home Policies approved for sale in Wisconsin are available from the Insurance Commissioner's office. Please send a large stamped, self-addressed envelope with each request.

Hospital Confinement Indemnity Insurance. These policies pay a fixed amount per day for a specific number of days. These policies are not related to Medicare and may not be necessary if you have a good Medicare supplement or Medicare replacement policy. Check on how many days you need to be hospitalized before coverage begins and the daily benefit you will receive after you become hospitalized.

Specified Disease Coverage. Policies which provide benefits for a single disease or group of specified diseases are not Medicare supplements. *These policies should not be bought as alternatives to Medicare supplement or Medicare replacement insurance.*

An INFORMATION SHEET ON CANCER INSURANCE prepared by the National Association of Insurance Commissioners is available by sending a stamped, self-addressed envelope to the Commissioner's office.

ATTENTION

There are several other policies marketed to the elderly. These include accident, travel accident, and intensive care policies. These are very limited in scope and do not provide the benefits important for people on Medicare and should not be used as a substitute for a Medicare supplement or Medicare replacement policy.

FILING A CLAIM

It is important to file claims properly. The following list will help:

Keep an accurate record of all your health care expenses with your health insurance policies.

Whenever you receive treatment, present your Medicare card and any other insurance card you have.

File all claims promptly. With each claim payment from Medicare, you will receive an "Explanation of Benefits." If the insurance company requests this, make a copy of it and write down the date you send the copy to the insurance company. Keep copies of any information you have concerning services received, the dates of services, and the persons who provided the services.

Many large clinics provide a special billing for your insurance company. If your physician does not, make sure that you get an *itemized* bill. This bill should include the date, type of service and amount charged for each service performed.

For more information on filing claims, you may want to contact the benefit specialist at your County Commission on Aging.

If you enroll in a health maintenance organization with a Medicare replacement policy, you will not have to file claims for covered services. All claims for covered services will be handled by the HMO.

POLICY CHECKLIST - 1989

Name of Company:

Name of Agent:

Cost of Policy:

Part A (Hospital)

	Basic Policy	Optional Benefits
Hospitalization		
Initial Deductible		
Skilled Nursing Facility		
1st to 8th Day		
Beyond 9th Day		
Home Health Care		
Inpatient Psychiatric Care		
Blood		
Part B (Medical)		
Medical Expenses		
Initial Deductible		
Medicare Approved expenses (after deductible)		
Beyond Medicare Approved Expenses		
Home Health Care		
Outpatient Psychiatric Care		
Blood		
Outpatient Prescription Drugs		
Part B Limit		
Other Benefits:		